REPORT

ON

HUMAN ARTIFICIAL REPRODUCTION AND RELATED MATTERS

ONTARIO LAW REFORM COMMISSION

Ontario

VOLUME I

Ministry of the
Attorney
General

1985

The Ontario Law Reform Commission was established by the *Ontario Law Reform Commission Act* for the purpose of reforming the law, legal procedures, and legal institutions. The Commissioners are:

James R. Breithaupt, CStJ, CD, QC, MA, LLB, *Chairman*

H. Allan Leal, OC, QC, LLM, LLD, DCL, *Vice Chairman*

Honourable Richard A. Bell, PC, QC, LLD

William R. Poole, QC

Barry A. Percival, QC

M. Patricia Richardson, MA, LLB, is Counsel to the Commission. The Secretary of the Commission is Diane L. Murdoch. The Commission's office is located on the Fifteenth Floor at 18 King Street East, Toronto, Ontario, Canada M5C 1C5.

During the course of the Reference on Human Artificial Reproduction and Related Matters, the Chairman, Dr. Derek Mendes da Costa, QC, left the Commission to take up an appointment as Judge of the Unified Family Court. Accordingly, while the Commission benefited greatly from Dr. Mendes da Costa's knowledge and experience and wishes to express its indebtedness to him, the recommendations contained in this Report do not necessarily reflect his views and cannot be attributed to him.

ISBN 0-7729-0001-9 (for set of two volumes)

ISBN 0-7729-0002-7 (Volume I)

TABLE OF CONTENTS

VOLUME I

Page

Letter of Transmittal xi

Glossary of Terms as Used in this Report xiii

Chapter 1 INTRODUCTION 1

Chapter 2 INFERTILITY IN ONTARIO: INCIDENCE, CAUSES, AND RESPONSES 9
- 1. Meaning of "Infertility" 9
- 2. Incidence and Causes of Infertility 10
- 3. Treatment of Infertility 14
  - (a) Conventional Responses 14
    - (i) Conventional Therapy 14
    - (ii) Adoption 15
  - (b) Non-Conventional Therapy 17
    - (i) Artificial Insemination 17
    - (ii) *In Vitro* Fertilization (I.V.F.) and *In Vivo* Fertilization Followed by Lavage 24
- 4. Conclusions 28

Chapter 3 PRESENT LAW IN ONTARIO AND THE CASE FOR REFORM 29
- 1. Introduction 29
- 2. Artificial Conception Services as the Practice of Medicine 30
- 3. Eligibility to Participate in Artificial Conception Programmes 36
  - (a) International Provisions 36
  - (b) National Provisions Relating to Discrimination and Civil Rights 39
    - (i) *Canadian Charter of Rights and Freedoms* 39
      - a. General 39
      - b. The Prohibition of Artificial Conception Technologies: Is There a Right to Procreate? 41

c. Discrimination in Access to the Reproductive Technologies 45

(ii) *Human Rights Code, 1981* 46

(iii) Conclusion 50

(c) The Canadian Medical Association *Code of Ethics* 51

(d) *Health Disciplines Act* and *Public Hospitals Act* 53

4. The Donation of Gametes 59

(a) The Individual Donor 60

(b) Sperm Banks 62

(c) Conclusion 63

5. Status of the Child, Parentage, and Birth Registration 64

(a) The Law and Practice Respecting Registration of Births Under the *Vital Statistics Act* 65

(b) The Establishment of Parentage Outside the *Vital Statistics Act* 73

(c) Birth Registration, Inheritance Rights, and the Posthumously Conceived A.I. or I.V.F. Child 75

(d) Conclusion 76

6. Medical Records: Composition, Retention, Access, and Confidentiality 78

7. Research and Experimentation on Human Genetic Material 83

8. Surrogate Motherhood: Contracts to Transfer Custody of Children and Parental Rights and Obligations 91

(a) Common Law Background 92

(b) The Present Position in Ontario 94

9. Conclusion: The Case for Reform 102

Chapter 4 ALTERNATIVE APPROACHES TO REFORM 105

1. Introduction 105

2. The "Private Ordering" Approach 107

3. The "State Regulation" Approach 110

(a) General 110

(b) Adoption Law in Ontario: A Model of State Regulation 111

4. The Present Ontario "Approach": A Disavowal of Extremes 117

5. Conclusions Respecting the General Approach to Reform 118
6. Ancillary Issues 123
    (a) Prohibition or Regulation? 123
    (b) The Instruments of Regulation 125
7. Conclusion 130

Chapter 5 REFORM AND PROPOSALS FOR REFORM IN OTHER JURISDICTIONS 131

VOLUME II

Glossary of Terms as Used in this Report xi

Chapter 6 PROPOSALS FOR REFORM 139

1. Introduction 139
2. The Propriety of Artificial Conception Technologies 140
3. General Recommendations for Reform 149
    (a) Artificial Conception Services as the "Practice of Medicine" 149
    (b) Eligibility for Participation in an Artificial Conception Programme 153
        (i) Criteria for Assessment: Marital Status and Other Matters 153
        (ii) The Refusal of Artificial Conception Services: Complaints and Appeals 159
    (c) The Donation of Gametes 160
        (i) Criteria for Selection of Donors 160
        (ii) Minors as Gamete Donors 162
        (iii) Consent of Gamete Donors 164
        (iv) Revocation of a Donor's Consent 166
        (v) Payments to Donors 167
        (vi) Frequency of Use of Donors 169
        (vii) Sperm, Ova, and Embryo Banks 171
        (viii) Importation of Gametes and Embryos from Outside Ontario 173
    (d) Status of Artificially Conceived Children: Parentage, Birth Registration, and Inheritance Rights 174

(i) Parentage of Artificially Conceived Children 174
a. Legal Status of Social Parents and Gamete Donors 174
b. The Nature and Form of a Husband's or Partner's Consent 176
(ii) Retroactive Recognition of Parentage 178
(iii) Registration of Birth 178
a. Where Donor Gametes are Used 178
b. Posthumous Artificial Conception, Where No Donor Gametes are Used 179
(iv) Inheritance Rights of Artificially Conceived Children 180
a. Where Donor Gametes are Used 180
b. Posthumous Artificial Conception, Where No Donor Gametes are Used 182
(e) Medical Records 183
(f) Artificial Conception and Legal Liability 190
(i) Concealment and Misrepresentation of Information by Gamete Donors 190
(ii) Products Liability and the Supply of Gametes and Embryos 191
(iii) Wrongful Conception, Wrongful Birth, Wrongful Life, and Dissatisfied Life Claims 194
4. Proposals Relating to the Fertilized Ovum Outside the Body 198
(a) Introduction 198
(b) The Simultaneous Transfer of Multiple Ova 199
(c) Control of a Fertilized Ovum Outside the Body 199
(i) General 199
(ii) Where No Donated Gametes are Used 203
(iii) Where Donated Sperm or Ova, or Both, are Used ... 204
(d) The Role of Gender Selection in the Transfer of a Fertilized Ovum 207
(e) Research and Experimentation on a Fertilized Ovum Outside the Body 207
(i) General 207
(ii) Transfer of Fertilized Ova Previously Subjected to Research or Experimentation 212

(f) Time Limits on the Development and Storage of Fertilized Ova 214

(g) The Cryopreserved Fertilized Ovum and the Rule Against Perpetuities 217

5. Proposals Relating to Surrogate Motherhood 218

(a) Introduction 218

(b) Approaches in Other Jurisdictions 221

(c) Policy in Principle 229

(d) Choice of a Regulatory Scheme 233

(e) The Proposed Regulatory Scheme 236

(i) The Prospective Parents 236

a. Medical Indications for Approval 236

b. Assessing the Parents: Marital Status and Other Factors 237

c. Use of Gamete Donors 239

(ii) The Surrogate Mother 239

a. Eligibility to Act as a Surrogate Mother 240

b. Assessment of Prospective Surrogate Mothers 241

(iii) The Court 242

a. Standard of Proof for the Approval of Agreements 243

b. The Prospective Surrogate Mother as a Co-Applicant 244

c. Blood, Tissue and Other Testing of Parentage 245

d. Participation of the Children's Aid Society 247

e. Confidentiality of the Proceedings and the Court Record 248

(iv) Terms of the Agreement 249

a. Surrender of the Child 249

b. Payment to the Surrogate Mother 253

c. Birth of a Handicapped Child 255

d. Abortion and the Surrogate Mother 257

e. Residual Terms of Surrogate Motherhood Agreements 259

(v) Status and Inheritance Rights of the Child 260

(vi) Agencies Arranging Surrogate Motherhood Agreements 261

(vii) Miscellaneous Issues 263

a. Failure of Flushing to Remove an *In Vivo* Fertilized Ovum 263

b. Introduction of Replacement Surrogate Mothers ... 264

c. Recognition of Surrogate Motherhood Agreements Made Outside Ontario 265

d. Medical Records 267

(viii) Failure to Comply with the Proposed Scheme 267

a. Penalties 267

b. Status of Children of Unapproved Surrogate Motherhood Arrangements 270

6. Further Review 272

SUMMARY OF RECOMMENDATIONS 275

VICE CHAIRMAN'S DISSENT 287

CONCLUSION AND ACKNOWLEDGMENTS 293

1. Conclusion 293

2. Acknowledgments 293

APPENDIX REFORM AND PROPOSALS FOR REFORM IN OTHER JURISDICTIONS 295

1. Introduction 295

2. Research and Reports 295

(a) Canada 295

(i) British Columbia, Royal Commission on Family and Children's Law 295

(ii) Alberta, Institute of Law Research and Reform 300

(iii) Health and Welfare Canada, Advisory Committee on the Storage and Utilization of Human Sperm 300

(iv) Law Reform Commission of Saskatchewan 304

(b) United Kingdom 311

(i) United Kingdom, Department of Health and Social Security, Scottish Home and Health Department, and Welsh Office 311

(ii) British Medical Association, Board of Science and Education, Panel on Human Artificial Insemination 313

- (iii) British Medical Association, Working Group on In Vitro Fertilisation 315
- (iv) Medical Research Council 318
- (v) Royal College of Obstetricians and Gynaecologists, Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer 318
- (vi) The Law Commission 324
- (vii) England, The Law Society, Standing Committee on Family Law, Human Fertilisation and Embryology ... 326
- (viii) Law Society of Scotland 328
- (ix) Department of Health and Social Security, Committee of Inquiry into Human Fertilisation and Embryology 331

(c) Australia 343
  - (i) Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization 343
    - a. *In Vitro* Fertilization, Artificial Insemination, and Donor Gametes 343
    - b. *In Vitro* Fertilization and "Surplus" Embryos 352
  - (ii) Queensland, Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters 357
  - (iii) South Australia, Working Party on In Vitro Fertilization and Artificial Insemination by Donor 366

(d) United States 370
  - (i) The American College of Obstetricians and Gynecologists 370
  - (ii) The American Fertility Society 371

3. Legislation 372
  - (a) Introduction 372
  - (b) Canada 374
    - (i) Quebec 374
    - (ii) Yukon Territory 375
  - (c) United States 375
    - (i) Artificial Insemination 375
      - a. General 375

b. Issues Addressed by Artificial Insemination Legislation 377
    (1) Married v. Single Women 377
    (2) Consent 378
    (3) The Donor 379
    (4) Medical Records 380
    (5) The Performance of Artificial Insemination and Its Implications 380
(ii) *In Vitro* Fertilization, Embryo Transfer, and Fetal Research 380
(d) Australia 383
    (i) Victoria 383
    (ii) New South Wales 389

Ontario
Law Reform
Commission

The Honourable Robert Welch, Q.C.,
Attorney General for Ontario

Dear Mr. Attorney:

We have the honour to submit herewith our *Report on Human Artificial Reproduction and Related Matters.*

GLOSSARY OF TERMS AS USED IN THIS REPORT

Amniocentesis	Withdrawal from the amniotic sac of a small sample of the fluid surrounding the growing fetus in order to detect certain fetal abnormalities.
Conceptus	Product of conception, that is, the embryo and membranes.
Embryo	An organism in the the early stages of development before recognizable human features have been formed.
Fallopian tubes	Tubes through which ovulated ova, which have been released from the ovaries, are transmitted into the uterus.
Fertilized ovum	Used interchangeably with "embryo".
Fetoscopy	Visual inspection of a fetus in the uterus.
Fetus	The developing embryo which has achieved recognizable human features (from the end of the eighth week to the moment of birth).
Gamete	An ovum or sperm.
Gene	A unit of heredity.
Implantation	The attachment of the fertilized ovum to the uterine wall.
Laparoscopy	Visual examination of organs by insertion of a light guide through a small incision in the abdominal wall. In this Report, "laparoscopy" is used to refer to the entire procedure by which ova are first visualized, and then recovered by a special needle fitted with a suction apparatus.
Lavage	The technique of "washing out" a fertilized ovum from a woman's uterus before implantation.
Ovum (pl. ova)	The female sex cell.
Semen	Fluid secretion containing sperm emitted during ejaculation.
Sperm	The male sex cell.
Ultrasound	Visualization of internal bodily structures by reflection of ultrasound waves.

CHAPTER 1

INTRODUCTION

On November 5, 1982, the Ontario Law Reform Commission received from the Attorney General for Ontario, the Honourable R. Roy McMurtry, Q.C., the following Letter of Reference:

> I wish to request that the Ontario Law Reform Commission inquire into and consider the legal issues relating to the practice of human artificial insemination, including 'surrogate mothering' and transplantation of fertilized ova to a third party. I would be pleased to have the Commission report on the range of alternatives for resolution of any legal issues that may be identified.
>
> In conducting your study, I would be grateful if you would include the following considerations within the scope of the review:
>
> 1. The legal status and legal rights of the child and the safeguards for protecting the best interests of the child.
> 2. The legal rights and legal duties of each biological parent.
> 3. The legal rights and legal duties of the spouse, if any, of each biological parent.
> 4. The nature and enforceability of agreements relating to artificial insemination and related practices.
> 5. The nature and enforceability of agreements respecting custody of the child.
> 6. The legal rights and liabilities of medical and other personnel involved in performing artificial insemination and other related practices.
> 7. The legal procedures for establishing and recognizing the biological parentage of children born as a result of these practices.
> 8. The applicability of present custody and adoption laws in such cases.
> 9. The availability of information to identify the child and the parties involved.
> 10. Such medical and related evidence as may have a bearing on the legal issues raised in these cases.
>
> I am certain that the Commission will appreciate the deep importance of these issues for the persons involved, particularly the children, and accordingly in the interests of these children, make the report available as soon as possible.

The Terms of Reference, set out in this letter, require us to examine the range of alternative solutions to the legal questions posed by the development and continuing refinement of medical and other scientific technologies for human artificial conception. While we are asked to consider only the relevant *legal* issues, we are acutely aware that these technologies pose, as well, profound philosophical, moral, ethical, social, and psychological questions that form the context within which the legal issues ultimately will have to be decided.

At the outset, it is critically important to identify the procedures that are the subject of this Report. We are concerned with four basic procedures involved in human artificial conception:

1. artificial insemination, which involves the intravaginal or intrauterine placement of semen by a syringe or similar means;
2. *in vitro* fertilization, also known as "test tube fertilization", which involves the fertilization of an ovum, which previously has been extracted from a woman, and the subsequent transfer of the fertilized ovum to a woman's uterus;
3. *in vivo* fertilization and embryo transfer, which involves the artificial insemination of a woman, removal of the fertilized ovum by a non-surgical lavage procedure, and subsequent transfer of the embryo to the uterus of another woman; and
4. "surrogate motherhood", which involves the application of one of the three technologies described above in order to produce a pregnancy in a woman who, pursuant to a prior arrangement, after the birth of the child surrenders it to another person or persons, who intend to raise the child as their own.

By combining the four fundamental procedures identified above and, in particular, by employing gamete (that is, sperm or ovum) donation, numerous permutations of artificial conception may be achieved in practice.[1] Of these, undoubtedly the most common is artificial insemination using the sperm of a third party donor, known as "A.I.D.", rather than that of the woman's husband or partner. The latter variation of artificial insemination is known as "A.I.H.". Artificial insemination by donor raises more difficult legal issues than A.I.H. and, hence, will receive greater emphasis in this Report.

The subject matter of this Reference could not be more timely or relevant. Medical technology in this area has left the law uncertain and confused in the wake of its rapid, apparently inexorable, development. Indeed, even in the course of this Reference, we have witnessed important technological advances that have dramatically affected the configuration of legal and other issues. For example, the first child produced by *in vivo* fertilization of a woman followed by transfer of the embryo to the uterus of another woman was born in California in early 1984.

That the law has been overtaken by scientific and technological advances is, in one sense, hardly unique. Throughout history, various changes in society have challenged the continuing relevance of the law in a world that has been fundamentally, often irreversibly, altered. Sometimes change has been effectively accommodated through the organic growth of the common law. In other instances, the change has been so dramatic that the common law has not been equal to the task of fashioning appropriate solutions; in such cases, legislative intervention has been necessary.

---

[1] For a list of the possible permutations, see Mason, "Abnormal Conception" (1982), 56 Aust. L.J. 347, at 347-48.

What distinguishes the technological advances that are the concern of this Report is that, arguably, they intrude into the most intimate and profound aspects of human existence. Reproduction, parenthood, and family are matters about which most persons hold deep convictions. These convictions often are based upon a certain moral or theological vision. It is the impact of the artificial conception technologies on these facets of our lives that gives this Reference its immediacy and importance and, indeed, its attendant controversy.

If further evidence be required of the special relevance of this Reference, we need only point to similar studies that recently have been conducted, or are in progress, in other jurisdictions. In the United Kingdom, a committee of inquiry was appointed under Dame Mary Warnock "[t]o consider recent and potential developments in medicine and science related to human fertilisation and embryology; to consider what policies and safeguards should be applied, including consideration of the social, ethical and legal implications of these developments; and to make recommendations".[2] The Committee reported in July, 1984. Prior to the appointment of the Warnock Committee, certain medical bodies in the United Kingdom had turned their attention to the issues posed by the advent of the new conception technologies.[3] In Australia, which has become a leading centre for *in vitro* fertilization, several bodies have been asked to examine these technologies, a few of which have submitted reports on some aspects of the issues.[4] Indeed, the law reform activity in certain Australian states has progressed to the point where legislation has been proposed[5] and, in two states, enacted.[6]

---

[2] United Kingdom, Department of Health and Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (Cmnd. 9314, 1984), at 4.

[3] See, for example, British Medical Association, Board of Science and Education, "Appendix V: Report of Panel on Human Artificial Insemination", Brit. Med. J. Supplement 3, Vol. II, April 7, 1973, at 3; British Medical Association, Working Group on In Vitro Fertilisation, "Appendix VI: Interim report on human in vitro fertilisation and embryo replacement and transfer" (1983), 286 Brit. Med. J. 1594; and Royal College of Obstetricians and Gynaecologists, *Report of the RCOG Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer* (1983).

[4] See, for example, the following reports by the Victoria Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization: *Interim Report* (1982); *Issues Paper on Donor Gametes in IVF* (1983); *Report on Donor Gametes in IVF* (1983); and *Report on the Disposition of Embryos Produced by In Vitro Fertilization* (1984). See, also, Queensland, *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters* (1984), and South Australia, *Report of the Working Party on In Vitro Fertilization and Artificial Insemination by Donor* (1984).

[5] See, for example, South Australia, *Family Relationships Act Amendment Act, 1984*, Bill No. 4.

[6] See Victoria, *Status of Children (Amendment) Act* 1984, No. 10069; Victoria, *Infertility (Medical Procedures) Act* 1984, No. 10163; New South Wales, *Artificial Conception*

In the United States, concern with some of the legal issues involved in artificial insemination by donor has led to the enactment of legislation at the state level.[7] Recently, there has been considerable activity in response to the evident proliferation of surrogate motherhood arrangements. Legislative proposals have been introduced in various state legislatures, although none of these proposals has been enacted.[8] Additionally, certain state governments have appointed committees to study surrogate motherhood.[9]

Apart from this activity, we can refer to a burgeoning scholarly literature dealing with all aspects of these technologies — scientific, legal, ethical, theological, social, and psychological — as further evidence of the particular timeliness of this Reference.

Underlying the Reference and the activity elsewhere is a general phenomenon, prevalent in Western nations, that explains, in large part, the perceived need for recourse to the new reproductive technologies. The incidence of infertility is widespread, and has been estimated to affect over fifteen percent of couples trying to conceive. Although medical treatment for infertility is available through family doctors and infertility specialists, only certain of the causes of infertility are curable by conventional therapeutic measures.[10] Hence, in the absence of other alternatives, couples suffering from causes that are not amenable to treatment will be unable to have children.

Act, 1984, Act No. 3, 1984; and New South Wales, *Children (Equality of Status) Amendment Act, 1984*, Act No. 6, 1984.

[7] See, for example, Alaska Stat. §25.20.045 (Supp. 1982); Cal. Civ. Code §7005 (West Supp. 1982); Conn. Gen. Stat. Ann. §45-69f-n (West 1981); Fla. Stat. Ann. §742.11 (West 1981); Kan. Stat. Ann. §§23-128 to 130 (1981); Minn. Stat. §257.56 (1982); N.Y. Dom. Rel. Law §73 (McKinney 1977); and Okla. Stat., tit. 10, §§551-53.

More than 20 states have enacted legislation governing fetal experimentation and research, several of which may apply to aspects of *in vitro* fertilization and embryo transfer: see, for example, Me. Rev. Stat. Ann., tit. 22, §1593 (West 1980); Mass. Ann. Laws, ch. 112, §12J (West Supp. 1983); Mich. Comp. Laws Ann. §§333.2685-333.2692 (West 1980); Mont. Code Ann. §50-20-108(3) (1981); N.M. Stat. Ann. §24-9A (1981); N.D. Cent. Code §14-02.2 (Allen Smith 1981); R.I. Gen. Laws §11-54 (Supp. 1982); S.D. Comp. Laws Ann. §34-23A-17 (1977); and Utah Code Ann. §76-7-310 (Allen Smith 1978).

[8] See, for example, H.F. 534 (Minnesota); A6624 (New York); H2098 (South Carolina); AB3139 (New Jersey); S.B. 485 (Kansas); and SB63 (Michigan).

[9] See, for example, Virginia, *Report of the Department of Welfare Study Committee on Surrogate Parenthood to the Senate Committee on Rehabilitation and Social Services and the House Committee on Health, Welfare and Institutions* (October, 1981); Maryland, *Report of the Committee to Study Surrogate Mother Programs in Maryland* (February, 1983); and Maryland, *Surrogate Mothering Programs in Maryland: A Study Conducted by Staff of the Department of Human Resources* (August, 1983). The General Assembly of Pennsylvania has passed a resolution providing for the appointment of a special committee to investigate surrogate parenting: see House Resolution No. 109 (June 21, 1983).

[10] See discussion, *infra*, ch. 2, sec. 3(a).

Apart from couples whose biological infertility frustrates conception or pregnancy, there are couples who decide not to attempt to have their own children, due to the presence of a harmful genetically transmissible condition in one or both of the partners.

For couples whose infertility is not amenable to treatment or who choose, for genetic reasons, not to produce children, adoption, the traditional way of introducing children into families, may be seen as an alternative. Yet, adoption is no longer a real, practicable, alternative means for overcoming their lack of children. As a consequence of various factors, there is simply a dearth of healthy newborn infants available for adoption.

Before we turn to explain how we proceeded in this Reference and to describe the organizational structure of this Report, we wish to comment briefly about the Terms of Reference in order to place our subsequent discussion in some perspective.

We wish first to reiterate our observation that the Terms of Reference ask that we report on the range of alternatives for resolution of the *legal* issues associated with artificial conception technologies. Accordingly, this will be the primary focus of our Report. We do acknowledge, however, the relevance of moral, ethical, and other perspectives that critically influence the evaluation of the legal issues and solutions.

We have taken special note of the particular concern of the Terms of Reference for the interests of children. That there is this emphasis is most appropriate. A particularly solicitous regard for the protection of the interests of children as a class and as individuals has long characterized the law and has been reinforced in recent Ontario legislation.[11] This concern is evident in the inherent *parens patriae* jurisdiction of the Supreme Court of Ontario and in the "best interests of the child" standard that pervades family law. Following the clear direction of the Terms of Reference, and consistent with the surrounding body of relevant law, we have placed a concern for the interests of artificially conceived children, and indeed for any children who might be affected by recourse to the new technologies, in the forefront of our deliberations. This concern has directed us to some conclusions that might not have been reached had a different priority prevailed.

In the Letter of Reference, the Commission has been asked to review ten enumerated considerations. We should indicate that, although not discussed separately and sequentially as discrete issues, these considerations have all been the subject of careful thought and analysis and may be found interstitially in the body of this Report.

Our final comment about the Terms of Reference concerns the nature of the subject matter that we have been asked to consider. The artificial conception technologies raise very difficult and controversial issues, which have given rise to a wide diversity of views to which we have paid due regard. This diversity of views may be attributable, in part, to an understandable ambivalence about or discomfort with artificial conception. Artificial conception appears to interfere in the natural process of creating human life, a matter that has long been considered mysterious, sacred, and personal. Taking human reproduction from the privacy of human intimacy into the clinical laboratory and the office of the lawyer, or introducing a third party into a marital relationship, even momentarily, so that a child may be conceived, may violate a sense of propriety and generate fears for the future welfare of the social order. That there is no consensus in the community in relation to many of the issues canvassed in this Report, but, instead, often sharply conflicting positions, makes the task of formulating recommendations for law reform all the more difficult.

---

[11] See *Children's Law Reform Act*, R.S.O. 1980, c. 68, as am. by S.O. 1982, c. 20, and *Child and Family Services Act, 1984*, S.O. 1984, c. 55.

We expect, therefore, that not all our proposals for reform will meet with universal approval. No doubt there will be those in the community who will consider that we have erred on one side or the other of particular issues, either by being indulgent of certain practices thought to be questionable or by being too restrictive of individual freedom. Yet, it must be borne in mind that, in formulating recommendations to answer vexing questions, we have sought to determine the appropriate response of public policy, rather than to dictate individual morality. The bounds of acceptable conduct may be wider in the case of the former. We have sought also in this Report to establish a sound basis for an informed and reasoned public discussion of the issues.

We wish now to outline generally the manner in which the Reference was conducted. Upon receipt of the Reference, the Commission retained Professor Bernard M. Dickens of the Faculty of Law, University of Toronto, as Project Consultant.

In recognition of the acute importance of this Project, an announcement, containing the Terms of Reference and inviting the submission of briefs, was placed in each daily newspaper published in the Province, and in the Ontario Reports. In addition, a copy of the announcement was circulated to a large number of persons and bodies in Ontario whom the Commission believed might be interested in its research. This group included the following: religious organizations; hospitals; medical schools; children's aid societies; the College of Physicians and Surgeons of Ontario; the College of Family Physicians of Canada; and the Ontario Branch of the Canadian Bar Association. The Commission received some thirty-five briefs, and we are very much obliged to all those who contributed so willingly to this study. Their valuable comments have been considered carefully by the Commission.

In order to place in perspective the many multidisciplinary issues involved in the Reference, an Advisory Board, comprising members of the professions of law, medicine, and social work and the disciplines of philosophy and ethics, was appointed. The Board met on a number of occasions to discuss the issues and tentative alternative proposals for reform suggested by the Commission. In addition, representatives of the Commission met with artificial insemination and *in vitro* fertilization specialists, who provided us with useful insights into the practical context out of which the legal and other issues have arisen. Finally, in order to obtain information concerning the present practice in Ontario of human artificial insemination, a questionnaire was sent, under the auspices of the Commission, to the Ontario practitioners whose names were listed in the directory of The Canadian Fertility and Andrology Society.

In the first substantive chapter of this Report, chapter 2, we shall discuss the problem of infertility and the means available to alleviate its consequences, including a description of the artificial conception technologies in present and reasonably forseeable use in Ontario. In chapter 3, we shall examine the existing legal framework in Ontario within which these technologies are being conducted. As we shall explain, the present law either does not respond directly, or responds inadvertently, to the novel legal issues raised by the new technologies. Such response is often, although not always, dysfunctional and inimical to all concerned, including the children artificially conceived. We conclude, therefore, that the uncertainty of the existing law warrants reform.

In chapter 4, we shall consider alternative approaches to law reform in this area. In large part, we regard the general issue as being whether the law should facilitate the exercise of free choice by participants in these procedures or should intervene, through the imposition of normative standards, to subordinate individual choice to other values important to the community. In the result, we do not select either of these paradigmatic approaches as being generally applicable to all the technologies in question, nor indeed to any one of them. We believe that the variety and complexity of the numerous issues raised by these technologies does not permit an *a priori* uniform response, but demands a flexible approach that addresses each issue individually.

Having explored the need for law reform arising from the inadequacy of the present law, and having examined alternative approaches to law reform, we shall turn in chapter 5 to discuss generally how other jurisdictions have decided, or have proposed to resolve, various issues in artificial conception. A more comprehensive discussion appears in the Appendix to this Report.

In chapter 6, we shall present our recommendations for reform. We shall first discuss those issues that are common to artificial insemination, *in vitro* fertilization, and *in vivo* fertilization and lavage, and we shall then consider particular issues relating to the fertilized ovum outside the body. The surrogate motherhood alternative, which, we believe, is fundamentally distinguishable from the other technologies, will be discussed separately in the final section of the chapter.

The Commission wishes first to express its gratitude to Professor Bernard M. Dickens, the Consultant to the Project, for his comprehensive working papers and patient guidance at all stages of the Project. His prodigious knowledge and deep understanding of the issues were of invaluable assistance to the Commission.

We also wish to record our appreciation to the members of the Advisory Board, who gave generously of their time and energy in preparing for, and attending, several day long meetings. The Advisory Board comprised the following persons: Professor David T. Armstrong, Department of Physiology and Department of Obstetrics and Gynecology, University of Western Ontario, London, Ontario; Mr. David R. Aston, Barrister and Solicitor, London, Ontario; Dr. Michael D. Bayles, Director, Westminster Institute for Ethics and Human Values, Westminster College, London, Ontario; Dr. John F. Jarrell, F.R.C.S.(C), Director of the Infertility Centre, Department of Obstetrics and Gynecology, McMaster University Medical Centre, Hamilton, Ontario; Professor Abbyann Lynch, Department of Philosophy, St. Michael's College, University of Toronto, Toronto, Ontario; Mr. Harry Nixon, F.C.A., Toronto, Ontario; Professor Ruth S. Parry, Director, Family Court Clinic, Toronto, Ontario; Mr. Lloyd W. Perry, Q.C., Official Guardian, Toronto, Ontario; Her Honour Judge J. Wilma Scott, Provincial Court (Family Division), Judicial District of Niagara North, St. Catharines, Ontario; and Dr. Paul Steinhauer, F.R.C.P.(C), Director of Training, Division of Child Psychiatry, Department of Psychiatry, University of Toronto, Toronto, Ontario. In particular, we wish to acknowledge the contribution of Dr. Jarrell. Throughout the course of the Project, he graciously assisted the Commission in a number of important ways.

The Commission also acknowledges with thanks the contribution of the artificial insemination and *in vitro* fertilization specialists who met with representatives of the Commission to discuss issues of mutual concern. Special thanks is due to Dr. Murray Kroach of the Toronto East General and Orthopaedic Hospital, who kindly responded to inquiries made by representatives of the Commission.

CHAPTER 2

INFERTILITY IN ONTARIO: INCIDENCE, CAUSES, AND RESPONSES

In the previous chapter, we observed that the perceived need for recourse to methods of artificial conception is a consequence of the incidence of infertility in the general population. In order to evaluate the validity of that perception, it is necessary to examine the statistical incidence of infertility, so far as this is possible, and to consider the efficacy of alternative solutions to the problem. It is only by addressing the latter that the degree of need for these new technologies can be ascertained.

Accordingly, in this chapter, we shall discuss, in a general fashion, the problem of infertility. We shall consider its causes and treatment, as well as the availability of alternative means to surmount its consequences. In the course of the discussion, we shall describe the practice of artificial insemination by donor in Ontario and outline generally the procedures involved in *in vitro* fertilization. We shall also discuss *in vivo* fertilization followed by lavage, a procedure that has not yet been undertaken in Ontario, but has been carried out elsewhere. A basic description of the artificial conception technologies in current and reasonably foreseeable use is a critical prologue to our discussion of the legal issues and our consideration of the alternatives for reform.

1. MEANING OF "INFERTILITY"

Throughout this Report, we shall be concerned with the medical disabilities of two groups of persons who wish to have children. The first group consists of couples who are "infertile", in the sense that they have attempted, but failed, to produce a child and do not respond to conventional therapy. This would include couples who in fact are fertile, but who have not conceived due, for example, to a low sperm count in the male. The second group, while capable of producing a child by natural reproduction, consists of couples of whom at least one person carries a genetic condition that he or she does not wish to transmit to the child. Among the diseases that are genetically transmissible are cystic fibrosis, Huntington's chorea, Tay-Sachs, and hemophilia.

In this chapter, we do not consider individuals who might wish to employ an artificial conception technology to produce a child for other than a medical reason. Thus, we do not address the situation of women who prefer not to interrupt their careers with a pregnancy, nor that of individuals who would like to become parents, but who lack partners for natural reproduction, and who do not wish to find one for the exclusive purpose of having sexual intercourse in order to produce a child. In our view, these reasons for choosing an artificial conception technology reflect personal choices that bear no relation to the issue of medical need with which we are here concerned. Whether such motives deserve recognition is an entirely different matter, which is intimately related to questions concerning the availability of the various technologies, and is better left to be addressed in that context.[1]

2. INCIDENCE AND CAUSES OF INFERTILITY

Before reviewing the statistical incidence of infertility and its causes, a few prefatory comments are in order. All the studies to which reference is made in this chapter have been conducted in clinical settings. No study of a general population has been undertaken for the purpose of generating statistics concerning the number of couples who are infertile and who fail to respond to conventional therapy. Thus, the statistics that are available relate only to couples attending infertility clinics, and who, therefore, clearly manifest some type of infertility problem. Nevertheless, these statistics do suggest the existence of an infertility problem in Ontario.

While there has been no published attempt to ascertain the incidence of infertility specifically in Ontario, among infertility practitioners whom we consulted there was a consensus that approximately 15-20% of couples striving to achieve a pregnancy are affected by infertility. Published reports of studies conducted elsewhere suggest a terminal infertility rate[2] of 10-15%.[3]

For purposes of assessing the potential utility of artificial conception technology, these statistics should be regarded as conservative. First, it must be recognized that not all couples having difficulty with conception seek clinical assistance. This hesitation may be attributable to the reluctance with which the subject of infertility has been discussed openly in the past. Only recently has the media given the topic serious attention, educating the public at a popular level about the possibility of treatment and the existence of alternative conception technologies to which recourse may be had. Secondly, the published statistics do not include couples who, for genetic reasons, choose not to attempt conception. Nor do these statistics include women who are considered to be habitual spontaneous aborters, who may constitute 2-3% of the aborting population.[4]

---

[1] See *infra*, ch. 6, secs. 3(b)(i) and 5(e)(i)a.

[2] The term "terminal infertility rate" refers to the percentage of couples who reach the end of their childbearing period without having produced a child.

[3] See, for example, Weir and Weir, "The Natural History of Infertility" (1961), 12 Fertility and Sterility 443 (12%); Southam, "What to Do with the 'Normal' Infertile Couple" (1960), 11 Fertility and Sterility 543 (10%); and Case and Zuspan, "Infertility" (1969), 49 Surgical Clinics of North America 121 (15%).

[4] One text has stated that approximately 15% of all pregnancies during the period between 4 and 20 weeks of gestation end in spontaneous abortion. Indeed, the actual rate may approach 50% due to the high rate of spontaneous abortion in the first 4 weeks after

A further indication of the incidence of infertility may be found in the increasing recourse to services offered by hospital infertility clinics. In 1965, the year of its inception, the Toronto General Hospital Reproductive Biology Unit treated 200 patients; almost 4,000 patients received services in 1983.[5] While only 28 couples visited the Mount Sinai Hospital Reproductive Biology Unit in 1973, 154 couples did so in 1982. Approximately 150 new couples are referred each year to the Infertility Centre at McMaster University. The number of patients receiving treatment by private specialists may well be higher.

There appears to be general agreement that the causes of infertility are distributed evenly among male factors, female factors, and a combination of both male and female factors.[6] In addition, there is a group called "normal infertiles" or, more accurately, "unexplained or idiopathic infertiles", for which no definite cause of infertility can be identified despite adequate medical investigation. Published studies have shown that this group has constituted from 6-60% of infertile couples,[7] with a mean of 15% of all infertile couples. The variation in the results may be explained by differences in the thoroughness and adequacy of the fertility investigation in individual studies. The majority of infertility specialists whom we consulted estimated that this group would constitute 10-20%

---

conception: see Speroff *et al.*, *Clinical Gynecologic Endocrinology and Infertility* (3d ed., 1983), at 484. See, also, Edmonds *et al.*, "Early Embryonic Mortality in Women" (1982), 38 Fertility and Sterility 447, which states that 62% of concepti are lost prior to 12 weeks of gestation.

[5] **Patients Treated at the Toronto General Hospital Reproductive Biology Unit, 1971-1983**

	Old Patients	*New Patients*	*Total Patients*
1971			1,418
1972			1,945
1973			2,085
1974			2,491
1975			2,367
1976	2,053	260	2,313
1977	2,276	226	2,502
1978	2,255	252	2,507
1979	2,070	226	2,296
1980	2,181	458	2,639
1981	2,555	407	2,962
1982	2,792	283	3,075
1983	3,532	385	3,917

This information was kindly furnished to the Commission by the Reproductive Biology Unit, Toronto General Hospital. Statistics respecting the number of new patients and old patients are not available for 1971-1975.

[6] An Israeli study, however, suggests that purely male factors account for 28% of infertility, while female factors account for 54%: see Dor *et al.*, "An Evaluation of Etiologic Factors and Therapy in 665 Infertile Couples" (1977), 28 Fertility and Sterility 718.

[7] See Templeton and Penney, "The incidence, characteristics, and prognosis of patients whose infertility is unexplained" (1982), 37 Fertility and Sterility 175, Table 1, which reviews the literature and clinic reports stating the incidence of unexplained fertility.

of infertile couples, although a single doctor contended that, if thorough investigation were undertaken, the result could be as low as 1-2%.

The general medical causes of infertility can be summarized readily. Male infertility may result from oligospermia or a low sperm density, or azoospermia or a complete absence of sperm in the ejaculate. The latter condition, we have been informed, affects approximately 12% of infertile men. Female infertility may be due to one or a combination of cervical, uterine, tubal, or ovarian causes.[8]

While we have mentioned medical factors that account for infertility, we should acknowledge the important contribution of societal factors. Statistical evidence confirms important trends of which we may be aware on an anecdotal level. In Ontario, people are marrying later in their lives[9] and, more importantly, couples are waiting longer before producing children. In addition, with the high incidence of divorce in our society, there has been a related increase in the number of second marriages. Consequently, many women are not attempting to

---

[8] For a discussion of causes of infertility, see, generally, Case and Zuspan, *supra*, note 3; Jones and Pourmand, "An Evaluation of Etiologic Factors and Therapy in 555 Private Patients with Primary Infertility" (1962), 13 Fertility and Sterility 398; and Raymont *et al.*, "Review of 500 Cases of Infertility" (1969), 14 Int. J. Fertil. 141.

[9] **Average Age of Bridegrooms and Brides at First Marriage, 1967-1982, Ontario**

Year	*Age at Time of First Marriage*	
	Bridegrooms	*Brides*
1967	24.9	22.4
1968	24.9	22.5
1969	24.9	22.6
1970	24.9	22.6
1971	24.9	22.6
1972	24.7	22.2
1973	24.7	22.3
1974	24.8	22.4
1975	25.0	22.6
1976	25.1	22.8
1977	25.2	22.9
1978	25.3	23.1
1979	25.4	23.2
1980	25.5	23.4
1981	25.8	23.6
1982	25.9	23.9

The figures for 1967-77 are to be found in Statistics Canada, *Vital Statistics, Volume II, Marriages and Divorces*, 1977 Catalogue 84-205, Annual, Table 3, at 6. The figures for 1978-82 are to be found in Statistics Canada, *Vital Statistics, Volume II, Marriages and Divorces*, Catalogue 84-205, Annual, in the appropriate annual catalogue in Table 1, at 2.

conceive until their late twenties, early thirties, or even later.[10] That the difficulty of achieving a pregnancy increases with age has been well documented.[11] The published studies, while in agreement concerning the importance of aging, differ as to the juncture at which female fertility declines significantly. Certain studies suggest that the "break point" is 30 years,[12] while others contend that it is 35.[13]

Other factors affecting the fertility of the population are the influence of certain industrial dangers and the effects of sexually transmitted diseases.

A final factor affecting infertility is that couples generally will seek professional assistance to alleviate their infertility problems only after several years of failed attempts. It has been demonstrated that, irrespective of maternal age, the efficacy of successful treatment of female infertility is affected adversely as the period of infertility prior to treatment is prolonged.[14]

At the outset, we identified a second group of persons who, while not infertile in the sense that we have discussed thus far, choose not to conceive due to the presence in one or both individuals of a genetic condition potentially harmful to their prospective children. It is virtually impossible to determine the number of couples who fall within this category without a study to ascertain the incidence of particular genetic traits in the population. Within this group are couples who already have produced a child or children having a chromosomal abnormality, or who have undergone genetic investigation and counselling that

---

[10] **Births Classified by Age Groups of Mothers, 1973-1982**

		Age Groups of Mothers	
Year	*20-24 (%)*	*25-29 (%)*	*30-34 (%)*
1973	33.2	34.6	14.1
1974	32.7	35.7	14.6
1975	32.8	36.4	14.7
1976	32.4	36.5	15.3
1977	32.2	36.1	16.9
1978	31.3	36.4	18.0
1979	30.4	36.9	19.0
1980	29.7	37.3	19.7
1981	29.0	37.5	20.5
1982	28.3	37.6	20.7

See Ontario, *Vital Statistics for 1982*, Table F (in part), at 14.

[11] See Schwartz and Mayaux, "Female Fecundity as a Function of Age" (1982), 306 New England J. Med. 404; Tulandi *et al.*, "Infertility in Women Over the Age of 36" (1981), 35 Fertility and Sterility 611; Weir and Weir, *supra*, note 3; Raymont, *supra*, note 8; Southam, *supra*, note 3; and Dor, *supra*, note 6.

[12] See, for example, Jones and Pourmand, *supra*, note 8.

[13] See, for example, Weir and Weir, *supra*, note 3; Raymont, *supra*, note 8; and Lamb, "Prognosis for the Infertile Couple" (1972), 23 Fertility and Sterility 320.

[14] See Jones and Pourmand, *supra*, note 8; Lamb, *supra*, note 13; Southam, *supra*, note 3; Sorenson, "Infertility Factors" (1980), 59 Acta. Obstet. Gynecol. Scand. 513; and Dor, *supra*, note 6.

indicate a high probability that future children will be affected in a similar manner.

3. TREATMENT OF INFERTILITY

Where there is a failure to conceive or to carry a child to term, medical assistance may be sought. At the first instance, the advice of the family doctor may be solicited, after which the couple may be referred to an infertility specialist engaged in private practice or associated with a hospital infertility clinic. Infertility clinics offer patients the services of various medical specialists, each of whose work relates to some aspect of the treatment of infertility.

Investigation of infertility involves a comprehensive study of a couple, which may extend over a period of several months. Besides a medical history and a routine physical examination of the man and woman, it includes certain anatomical examinations and hormonal tests, the latter of which are directed to ascertaining whether ovulation is occurring properly.[15] In all our discussions, infertility specialists emphasized that, for the patients, infertility investigation is a very demanding and acutely stressful experience.

If, at the culmination of the investigation, the particular cause or causes of infertility can be ascertained, remedial measures may be taken. These may range along a continuum from simply counselling a couple in relation to the frequency and timing of intercourse to the more esoteric artificial conception technologies with which we are concerned in this Report.

In the following section, we shall touch briefly on the conventional responses to infertility, and then proceed to describe artificial insemination and *in vitro* fertilization as they are conducted now in the Province of Ontario. We shall also discuss the relatively new procedure of *in vivo* fertilization followed by lavage.

(a) CONVENTIONAL RESPONSES

(i) Conventional Therapy

As we have stated, infertility treatment may be understood as a continuum of responses to a problem. Conventional therapy may be as innocuous as counselling a couple about intercourse or advising them about general health. It also may include both hormonal treatment and surgical intervention. Many couples affected by infertility will respond eventually to conventional therapy and conceive, although several years of treatment may be required before a pregnancy is achieved. The success rate of corrective measures is affected by factors that we have identified previously as affecting fertility generally, for example, the age of the patient and the duration of infertility at the time of the initial visit.

---

[15] For a general description of the various tests involved in infertility investigation, see Thomas and Forrest, "Infertility: A Review of 291 Infertile Couples Over Eight Years" (1980), 34 Fertility and Sterility 106; Dor, *supra*, note 6; Raymont, *supra*, note 8; and Newton *et al.*, "The Changing Pattern of a Comprehensive Infertility Clinic" (1974), 6 J. Biosoc. Sci. 477.

As a general rule, female infertility is considerably more capable of treatment by conventional therapy than male infertility.[16] While there are both hormonal and surgical therapies for semen abnormality, these often have been inappropriately validated and, as a consequence, the results are often unpredictable.[17] With respect to female infertility, certain causes are more amenable to curative measures than others. Tubal problems may be treated by surgery and the success rate varies with the particular tubal disorder. Of all the types of problems, ovulatory disturbances, which are treated by hormonal drugs, appear to be the most easily ameliorated.[18]

For infertile couples who do not respond to conventional therapy or who fail to conceive after the passage of time, resort will have to be made to another alternative if a child is to be brought into the family.

(ii) Adoption

Traditionally, the alternative that has come most readily to mind has been adoption. Indeed, until the advent and refinement of the artificial conception technologies were brought to public attention, adoption may have been seen as the exclusive means of relieving childlessness. For many couples, however, adoption is no longer a real alternative to infertility. As a consequence of various factors — increasing social acceptability of single mothers, greater willingness on the part of unwed mothers to rear their own children,[19] accessibility of birth control knowledge and technology, and the 1968 amendments to the *Criminal Code* affecting the availability of abortion[20] — fewer healthy infants are available for adoption. While older or handicapped children or infants of certain racial or ethnic backgrounds may be available, many couples may regard this as a less desirable option.

---

[16] For a discussion of the relative success of various therapeutic measures, see Jones and Pourmand, *supra*, note 8; Case and Zuspan, *supra*, note 3; Dor, *supra*, note 6; and Thomas and Forrest, *supra*, note 15. A recent article suggests that, in the absence of azoospermia, bilateral tubal obstruction or amenorrhea, the efficacy of therapies for treating infertility remains incompletely validated: see Collins *et al.*, "Treatment-Independent Pregnancy Among Infertile Couples" (1983), 309 New England J. Med. 1201.

[17] See De Kretser, "The Management of the Infertile Male" (1974), 1 Clinics in Obstetrics and Gynecology 409.

[18] See Thomas and Forrest, *supra*, note 15.

That there has been a dramatic decrease in the number of newborns available for adoption is evident in the number of placements effected by children's aid societies. In 1969, the Children's Aid Society of Metropolitan Toronto placed 1,239 children for adoption, of whom 961 were infants. Eight years later, the same agency placed 190 children, including 90 infants. In 1982, 173 adoptions were completed, of which 73 involved infants.[21]

Apart from the problem of supply, adoption may be a less attractive alternative than an artificial conception technology that allows the child produced thereby to be related genetically to at least one of the partners. Moreover, from the perspective of couples, adoption may be regarded as an unduly intrusive interference with their lives, insofar as the approval process subjects them to thorough and detailed scrutiny by social workers, which inevitably compromises their personal privacy. We shall return briefly to a discussion of this aspect of

---

[19] **Live Births to Unmarried Mothers**

Year	*Births to Unwed Mothers*	*Rate per 1000 Live Births*	*Proportion of Unwed Mothers Who Keep Their Children (%)*
1968	9.463	75.0	30.1
1969	9,802	75.2	30.1
1970	10,248	76.1	48.5
1971	8,492	65.1	52.1
1972	8,437	67.5	67.7
1973	8,285	66.9	70.3
1974	8,286	66.7	78.8
1975	8,816	70.0	80.6
1976	9,301	75.8	82.2
1977	9,608	78.3	88.3

See Ontario, Provincial Secretariat for Social Development, *The Family as a Focus for Social Policy* (1979), Table 8, at 19.

A similar trend has been identified in the United States: see *Hearings on Examination and Exploration of Existing and Proposed Federal Policies Affecting the Adoption of Children and Their Placement in the Foster Care System Before the Subcomm. on Children and Youth of the Senate Comm. on Labor and Public Welfare*, 94th Cong., 1st Sess. 6 (1975).

[20] *Criminal Code*, S.C. 1953-54, c. 51, s. 237, as am. by S.C. 1968-69, c. 38, s. 18. See, now, *Criminal Code*, R.S.C. 1970, c. C-34, s. 251.

[21] See Children's Aid Society of Metropolitan Toronto, "Adoption in the Eighties" (1983), 20 Our Children 6.

adoption in Ontario in chapter 4.[22] At this juncture, it is important to note that the process itself may be perceived as threatening.

Therefore, although adoption remains a theoretical solution to infertility, its practical availability is severely restricted, due to a combination of factors, the most significant of which is the intractable problem of a dearth of healthy newborn infants available for adoption.

(b) NON-CONVENTIONAL THERAPY

(i) Artificial Insemination

In the previous discussion, we observed that certain causes of infertility are amenable to treatment with the application of conventional therapy depending, of course, on particular factors related to the individual. Other causes are not capable of treatment. Where, for example, the cause of infertility is azoospermia due to severe testicular damage, the only possible treatment is artificial insemination of the woman using donor semen.

Artificial insemination in itself is a relatively simple mechanical procedure that consists of the intravaginal or intrauterine placement of semen by a syringe or similar means. The sperm may be that of the husband or partner (A.I.H.), but is more often that of a third party donor (A.I.D.), who is almost invariably a person unknown to the inseminated woman.[23]

Since artificial insemination is an uncomplicated procedure that does not demand elaborate or expensive apparatus, its performance is in fact not restricted to doctors;[24] persons without any medical training can acquire the ability necessary to undertake the procedure. However, when properly undertaken by an infertility specialist, whether in private practice or operating out of a hospital infertility clinic, the entire process of artificial insemination by donor may incorporate several ancillary procedures, most of which have a decidedly medical character. These procedures may include donor selection and screening; sperm testing and storage; medical, and possibly psychological, assessment of the recipient; "matching" of the donor and the recipient's spouse or partner to avoid incompatibility; treatment of the recipient to regulate ovulation; and the determination of the menstrual cycle of the recipient with a view to choosing the optimum timing for insemination.

---

[22] See *infra*, ch. 4, sec. 3(b).

[23] Occasionally, the sperm of a husband with a low sperm count or poor sperm motility is mixed with that of a donor, in combined or confused artificial insemination, which is referred to as A.I.C. This creates a possibility that a resulting child is that of the husband. This procedure came into use, however, before blood testing of children and donors could establish positive paternity with a high level of reliability. Today, such testing can show whether the husband or the donor is the father. Accordingly, A.I.C. can be unravelled, and exposed in fact as either A.I.H. or A.I.D. We have been advised that the procedure is rarely used.

[24] With respect to whether, as a matter of law, the practise of artificial insemination is restricted to persons licensed to practise medicine under the *Health Disciplines Act*, R.S.O. 1980, c. 196, see *infra*, ch. 3, sec. 2.

Among the specialists whom we consulted, there was a consensus that artificial insemination by donor is successful in at least 60% of cases. It was estimated that approximately 95% of couples seeking artificial insemination by donor are referred for this treatment due to a low sperm count in the husband, while 5% are referred because the husband is carrying a potentially harmful genetic condition that the couple does not wish to pass on to a child.

In Ontario, artificial insemination by donor is by no means a new method of treatment for couples whose inability to conceive is caused by male infertility.[25] The procedure has been in use in this Province for well over a decade in university medical centres and by private practitioners, and is considered acceptable medical treatment. It is difficult to estimate the number of artificial insemination by donor procedures conducted annually in the Province. Although artificial insemination is listed in the fee schedule of the Ontario Health Insurance Plan (O.H.I.P.), O.H.I.P. records do not distinguish between A.I.H. and artificial insemination by donor. Thus, these records are of marginal utility as an indicator of the degree to which artificial insemination by donor is sought. Moreover, we understand that many patients prefer to pay cash in order to avoid recording the fact of the procedure in the O.H.I.P. medical history computer. As an aside, it should be noted that the O.H.I.P. statistics made available to the Commission do demonstrate a generally steady increase in recourse to some form of artificial insemination.[26]

The practice of artificial insemination by donor in the Province of Ontario is not expressly regulated. Neither legislation nor professional guidelines have addressed this procedure, leaving it to the discretion of individual physicians. Of course, the conduct of physicians performing artificial insemination must fall within the general confines of the *Health Disciplines Act*[27] and also the Canadian Medical Association *Code of Ethics*, to which the College of Physicians and

---

[25] For a very general discussion of artificial insemination in Canada, see Rioux and Ackman, "Artificial Insemination and Sperm Banks: The Canadian Experience", in David and Price (eds.), *Human Artificial Insemination and Semen Preservation* (1979) 31.

[26] O.H.I.P. figures for the 5 fiscal years 1979-80 to 1983-84 are as follows:

1979-80	*1980-81*	*1981-82*	*1982-83*	*1983-84*
6,525	7,957	8,356	10,360	9,973

These figures, it should be noted, represent the number of individual procedures. No figures are available as to the number of patients who receive artificial insemination. Since the number of procedures that may be performed on a woman prior to conception varies, it is not possible to estimate the number of women receiving artificial insemination in Ontario.

These statistics were kindly provided to the Commission by the Ministry of Health, Information Resources and Services Branch.

[27] *Supra*, note 24.

Surgeons of Ontario subscribes.[28] Moreover, if physicians are associated with a university hospital infertility clinic, their conduct must conform to the policies of that institution. Fundamental questions, several of which are infused with difficult issues of social policy and morality, are being resolved daily in the course of practice by hospital infertility clinics and by individual physicians. As a consequence, a uniform provincial practice does not exist. In the United States, on the other hand, The American Fertility Society[29] has devised guidelines for the selection and management of donors and recipients and respecting semen cryopreservation.[30]

The practice of artificial insemination by donor raises several important issues that bear upon our fundamental concern for the best interests of the child. First, there is a question whether the availability of the procedure should be restricted in any manner so as not to facilitate the birth of children to certain persons or in certain circumstances. This might be done by prescribing eligibility criteria or by allowing services to be withheld on an *ad hoc* basis by individual doctors or clinics. The issue of eligibility for treatment has been cast usually in terms of the propriety of affording artificial insemination by donor to single women and to unmarried couples, although the general question should not be seen only within that narrow compass. Whether the availability of services should be restricted at all and, if so, according to what criteria, are questions common to all means of artificial conception with which we are concerned in this Reference.

A second issue relates to the selection and screening of sperm donors in order to match the characteristics of the social father and to prevent the transmission of disease or other disadvantage to the offspring.

A third consideration relates to the maintenance of records of patients and donors and whether a system of linkage should be established between them. It will be recalled that the semen donor and recipient are ordinarily unknown to each other. A linkage system operates as a means of bridging the chasm of anonymity between donor and recipient when, for a medical reason, a doctor must communicate with one or the other of them in order to transmit vital information. It should be emphasized that, as a practical matter, a linkage system does not involve the disclosure of the identity of either donor or recipient, as it is the medical information not the identity of the participants, that is crucial to effective treatment. Recourse would be made to such a system where, for example, a child born as a consequence of artificial insemination by donor has congenital hereditary spherocytosis, a disease that can be genetic or spontaneous.

---

[28] The College of Physicians and Surgeons of Ontario has not yet provided any guidelines or standards for physicians practising A.I.D. By contrast, homologous artificial insemination and artificial insemination by donor have been addressed, albeit briefly, by the Judicial Council of the American Medical Association: see American Medical Association, *Current Opinions of the Judicial Council of the American Medical Association — 1984* (1984), at 3-4.

[29] See The American Fertility Society, *Report of the Ad Hoc Committee on Artificial Insemination* (1980).

[30] Cryopreservation means preservation by means of freezing.

Where the donor is still active, it would be important to conduct further testing for hemolysis of red cells to ascertain whether he has transmitted the disease to the infant.[31]

A further issue related to the maintenance of records is whether the doctor who has performed artificial insemination should be under a duty to make all reasonable attempts to discover whether the procedure has been successful.

In an effort to ascertain how these and other issues are being resolved in practice, the Commission arranged for the circulation of a questionnaire to the Ontario doctors whose names were listed in the directory of The Canadian Fertility and Andrology Society. The questionnaire was prepared in consultation with Dr. John F. Jarrell, Director of the Infertility Centre, Department of Obstetrics and Gynecology, McMaster University Medical Centre.[32] The questionnaire sought to establish whether there was a pattern to the practice of artificial insemination by donor in the Province of Ontario with respect to a broad range of issues. Additionally, it sought to discover whether the practice of individual practitioners differed generally from that followed in university health centres in relation to any of the issues. The responses to the questionnaire were analyzed by Mrs. Ruth Milner of the Design Measurement Evaluation Programme of McMaster University.

Of thirty-seven questionnaires circulated, twenty-nine were returned. Of these, the majority indicated use of husband's semen, where possible, while slightly over half the respondents also used donor semen. Physicians who were not involved with artificial insemination by donor were asked not to answer any further questions once this fact was established, leaving sixteen respondents in total. Owing to the limited number of respondents, we shall not refer to percentages in our discussion, but shall simply review the discernible trends in the practice.

On the issue of eligibility or access to services, the practitioners were questioned in relation to five classes of patient: "single" women, that is, women, whether or not married, who are not involved in a relationship with a male; unmarried couples; couples demonstrating ambivalence to the procedure; couples where one partner is mentally retarded; and couples with very limited financial resources. Respondents were asked whether they treated patients falling within these descriptions, and if so, to what extent.

---

[31] We have been informed that in fact a link has been used for just such a purpose. The testing of the donor was negative, indicating that the disease had been caused by a spontaneous mutation. A second example of a case where linkage may be useful arises where the child is born with cystic fibrosis, a lethal disease autosomal recessive in nature. Where access to the link shows that the donor is responsible for other pregnancies, the doctor responsible for the artificial inseminations may wish to conduct further testing of the donor, should he be available, and notify the parents of the other children to inform them of the possibility that an abnormal gene may cause a disease in their children.

[32] See Jarrell and Milner, "Patterns of Practice of Artificial Insemination by Donor in Ontario", presented at the Joint Annual Meeting of The Canadian Fertility and Andrology Society and British Fertility Society, held at Vancouver, British Columbia (Sept. 6-8, 1984).

With respect to the treatment of single women, the following conclusions can be drawn from the responses to the questionnaire. With one exception, the responses revealed that single women request treatment rarely. Even in the exceptional case, single women constitute a very small proportion of those presenting themselves for artificial insemination.

In the treatment of single women, there appeared to be variations among the practices of individual physicians. Respondents associated with a university either never treat single women or do so only occasionally, with the majority indicating the former. However, a majority (5) of the private practitioners indicated that they occasionally treat single women and a minority (3) usually treat the few who request treatment. Only one private respondent indicated that single women had never been treated in the course of his practice. In answer to a query respecting their reasons for not treating single women, respondents offered several justifications, the most common being the presence of moral reservations and legal concerns.[33]

The practice in relation to unmarried couples is that most respondents either usually treat them or occasionally treat them, with the majority falling into the former category. Approximately one-third of the respondents indicated that they never treat unmarried couples.

Where a couple requesting treatment demonstrates ambivalence in relation to the proposed procedure, the majority of both university and private practitioners refuse to provide treatment.

In response to the question concerning the treatment of couples where one member is mentally retarded, all the private practitioners indicated either that this issue had never arisen for their decision or that they had never accorded treatment to them. Some of the university centres have occasionally provided treatment in such circumstances.[34]

The financial resources of the couple requesting artificial insemination by

---

[33] In a study of the practice of artificial insemination by donor in the United States, it was reported that at least 9.5% of the practitioners had provided artificial insemination to single women: see Curie-Cohen *et al.*, "Current Practice of Artificial Insemination by Donor in the United States" (1979), 300 New England J. Med. 585.

[34] The following chart summarizes the responses:

Management of Couples Where One is Mentally Retarded

	Number of Respondents	*University*	*Private*
Always Treated	0	0	0
Usually Treated	0	0	0
Occasionally Treated	3	3	0
Never Treated	6	2	4
Never Had to Make Decision	6	2	4
	15		

donor appear to be largely irrelevant to treatment. Most respondents indicated that they always treat or usually treat couples with very limited financial resources. Only one respondent indicated that he refuses to provide treatment in light of this consideration.

Certain additional questions were directed to ascertaining the weight given to various factors by practitioners in accepting or rejecting a couple for artificial insemination by donor. Responses to these questions revealed the crucial importance of the husband's consent to the procedure, without which a couple will not be accepted for treatment. As a factor favouring rejection, substantial emphasis was placed on whether a divorce was pending and on the sexual orientation of the woman. These factors, in conjunction with the preference for married couples and the desire to ensure that there is no ambivalence to the procedure on the part of the couple, would appear to evince a concern for the general stability of the relationship of the couple, particularly in relation to the procedure itself. However, few respondents indicated that any significant emphasis is placed on a psychiatric assessment or home study of the couple presenting themselves for treatment.

Before turning to review the practice respecting donor screening, we wish to emphasize that, while the preceding discussion has focused on the possible reasons for denial of treatment, our survey of the practice in Ontario indicates that in fact treatment is rarely refused. Most of the respondents to the questionnaire, including all the university practitioners, indicated that from one to five patients are refused treatment per year. Only a few respondents reported greater levels of denial.[35]

Practices respecting donor screening appear to vary considerably. The most common tests, which are either given by the doctors or required by them to be done in a laboratory, are blood group and type, semen analysis and culture, and VDRL.[36] Less frequent tests are CBC[37] and hepatitis, with still fewer responses reporting karotype, genetic screening,[38] and the taking of a family or general history of the donor. Other tests were listed by some practitioners.

---

[35] The following chart summarizes the extent of refusal of treatment:

Number of Patients Refused	*Number of Respondents*
0	0
1-5	11
6-10	1
11-15	1
16-20	1

[36] "VDRL" refers to "Venereal Disease Research Laboratory", a standard test for syphilis.

[37] "CBC" refers to "Complete Blood Count", a standard test of the hemoglobin, hematocrit, and white blood cell count.

[38] See, generally, Fraser and Forse, "On Genetic Screening of Donors for Artificial Insemination" (1981), 10 Amer. J. Med. Genetics 399. In a study of the practice of A.I.D. in the United States, it was concluded that the screening of donors for genetic disease was inadequate: see Curie-Cohen, *supra*, note 33. See, also, Timmons *et al.*, "Genetic Screening of Donors for Artificial Insemination" (1981), 35 Fertility and

The number of donors used by the respondents ranged from less than five to more than twenty. A single practitioner indicated reliance on frozen semen purchased from a commercial bank in the United States. We are advised that commercial sperm banks, which do not now exist in Canada, offer the advantages of ensuring high quality in the material, which is achieved by very intensive screening of donors, and a broader range of ethnic and phenotypes for matching the partner of the recipient than may be available when fresh semen is used. A disadvantage of frozen semen is that its success rate compares unfavourably with that of fresh semen.[39]

The treatment of medical records maintained in the course of artificial insemination by donor demonstrates a recognition on the part of the practitioners of the acute sensitivity of the matter to the parties concerned and an awareness of the potential utility of a system of linkage between donors and recipients. A significant majority of the respondents indicated that they had instituted measures to afford special security for donor and recipient records, above that usually given to ordinary medical records. Interestingly, a single respondent indicated that a record of the donors was not maintained.

A system of linkage[40] had been established by all but two of the respondents. Where such a system had been instituted, in almost all cases the donors and recipients were made aware of its existence.

On the question of "follow up" of the results of the artificial insemination, it would appear that the general practice is to strive to ascertain the results of the operation both after conception and after birth. It is probable that, at present,

---

Sterility 451, which concluded that reliance on self-assessment by semen donors as a method of genetic screening is insufficient.

[39] For a comparison of the efficacy of fresh semen and frozen semen, see, for example, Beck and Silverstein, "Variable Motility Recovery of Spermatozoa Following Freeze Preservation" (1975), 26 Fertility and Sterility 863; Ansbacher, "Artificial Insemination with Frozen Spermatozoa" (1978), 29 Fertility and Sterility 375; and Matthews *et al.*, "The Influence of Insemination Timing and Semen Characteristics on the Efficacy of a Donor Insemination Program" (1979), 31 Fertility and Sterility 45. But see McCoshen *et al.*, "Effectiveness of Human Semen Frozen in TEST-Yolk-Buffered Medium on AID Outcome", presented at the Joint Annual Meeting of The Canadian Fertility and Andrology Society and British Fertility Society, held at Vancouver, British Columbia (Sept. 6-8, 1984).

[40] For example, an anonymous linkage system has been established in the Infertility Centre, Department of Obstetrics and Gynecology, McMaster University Medical Centre. The semen donor file is kept in a separate location from the recipient file. Each donor is assigned a number, which then is translated into a letter or a series of letters. Although the donor knows his number, he is not made aware of his letter. The chart of the recipient will record the date of insemination, the letter assigned to the donor, and the quality of the sperm. The policy of McMaster University is that access to both the donor file and the recipient file is restricted to the Director of the Infertility Centre and the Chief Executive Officer of the hospital. All parties are informed of the existence of the linkage system. Based on the experience thus far, it would appear that the necessity of a system of linkage has been accepted by the recipients and the donors, many of whom request to be informed if a child with a genetic disorder is born.

many physicians rely on a passive system rather than an active system: instead of attempting to communicate with the patient, the latter is requested to advise the physician about the outcome of the pregnancy.

These follow-up procedures have provided information respecting the outcome of artificial insemination by donor in Ontario and, in particular, whether any infants have been born with medical problems. Apparently, very few congenital anomalies have arisen, with only two doctors reporting either two or three each year. Even fewer reported the transmission of infectious disease.

(ii) *In Vitro* Fertilization (I.V.F.) and *In Vivo* Fertilization Followed by Lavage

In vitro fertilization has been introduced in Ontario only recently. The Toronto East General and Orthopaedic Hospital first initiated this procedure in its so-called "LIFE" (Laboratory Initiated Foetal Emplacement) Program. Recently, *in vitro* fertilization programmes have been instituted by McMaster University Medical Centre, University of Toronto, and the University of Western Ontario. Elsewhere in Canada, there are several existing or planned clinics. Outside Canada, there are numerous *in vitro* fertilization clinics, the most notable of which are located in England, Australia, and the United States.[41]

Certain types of infertility that are not otherwise amenable to treatment by conventional means may be treated by *in vitro* fertilization. Where, for example, female infertility is caused by obstruction of the fallopian tubes, which prevents passage of the egg from the ovary to the uterus, or by the absence of fallopian tubes, this procedure would effectively surmount that barrier. Indeed, *in vitro* fertilization has been used to respond to all causes of female infertility, except for intractable anovulation and the absence of a uterus.[42]

The procedures followed in the LIFE Program in Toronto generally resemble those employed in *in vitro* fertilization clinics elsewhere. Since the techniques involved in *in vitro* fertilization treatment are evolving constantly, specific aspects of the procedures vary with individual institutions.[43] Notwithstanding the diversity inherent in independent innovation, the main features of *in vitro* fertilization can be discussed briefly.

---

[41] For a survey of the results achieved in various *in vitro* fertilization clinics, see Grobstein *et al.*, "External Human Fertilization: An Evaluation of Policy" (1983), 222 Science 127, especially Table 1, at 128.

[42] See Johnston *et al.*, "In Vitro Fertilization: The Challenge of the Eighties" (1981), 36 Fertility and Sterility 699. "Anovulation" means the suspension or cessation of ovulation.

[43] See, generally, Annas and Elias, "*In Vitro* Fertilization and Embryo Transfer: Medicolegal Aspects of a New Technique to Create a Family" (1983), 17 Family L. Q. 199. See, also, The American College of Obstetricians and Gynecologists, Committee on Gynecologic Practice, "Human In Vitro Fertilization and Embryo Placement", in ACOG Committee Statement (April, 1984) (hereinafter referred to as "ACOG Committee Statement"). Committee Statements are not considered policy of The American College of Obstetricians and Gynecologists.

In vitro fertilization, as conducted in the LIFE Program,[44] and indeed elsewhere, involves four basic steps. First, a mature ovum is removed from the ovary, generally by laparoscopy while the patient is under a general anaesthetic. Laparoscopy is a minor operation, involving the insertion of a slender instrument called a laparoscope through the abdomen to visualize the ovaries in order to recover the ovum. The ovum is actually recovered by a special needle fitted with a suction apparatus. Critical to the success of the procedure is the timing of the harvesting of the ovum. It must be obtained immediately prior to ovulation, at which time it would be ejected from the ovary as part of the natural menstrual cycle. In order to determine precisely when ovulation, which varies with individuals, is about to occur, several tests, including ultrasound, hormonal, and blood tests, must be conducted at periodic intervals.

Certain *in vitro* fertilization clinics, including the LIFE Program, hormonally stimulate menstrual cycles in order to produce multiple eggs. Since laparoscopy involves certain risk and discomfort to the patient, it is desirable to minimize its use and maximize its effectiveness. Fertilization of an ovum cannot be guaranteed at each exposure *in vitro;* therefore a greater likelihood of success is sought by recovering multiple ova and then exposing them *in vitro*. Furthermore, the probability of successful implantation and pregnancy is increased by transferring to the uterus three or four fertilized ova. This also increases the possibility of a multiple pregnancy, which has, on occasion, ensued.

The second stage involves the fertilization of the ovum with a semen specimen, which is obtained four to six hours after the removal of the ovum and suitably prepared. Fertilization takes place in a dish, which itself is contained in a specially prepared incubator.

Upon fertilization, the egg is permitted to develop in a growth medium for a period of forty-eight to seventy-two hours. After the growth stage, if the fertilized egg has developed properly, it will be transferred in the final stage to the uterus of the mother by means of a small catheter, which is inserted through the cervix.

A recent survey[45] of *in vitro* fertilization clinics indicates that the efficacy of this procedure has been improving steadily, with the most experienced clinics showing the best success rates. Improved results have been attributed to the development of certain technical innovations, which have increased the probability of achieving a pregnancy. Particularly significant measures include the production of multiple eggs through hormonal stimulation of the menstrual cycle, incubation of the eggs prior to fertilization in order to ensure full maturation, and the transfer of multiple eggs to the uterus. It would appear that the most precarious stage of the *in vitro* fertilization procedure is the transfer of the fertilized ovum to the uterus.

An evaluation of the efficacy of *in vitro* fertilization depends not only on the rate of pregnancy achieved, but also on whether the procedure involves any medical dangers to the woman and the unborn infant. Risk to the woman arises from the surgical operations involved in *in vitro* fertilization and from the possibility of an ectopic pregnancy.[46] In relation to the child, attention has been drawn to the death rate among early embryos and the possibility of induced congenital abnormality.[47]

---

[44] See Khamsi *et al.*, "In Vitro Fertilization (IVF)" (1984), 61 U. Toronto Med. J. 58.

[45] See Grobstein, *supra*, note 41.

While the relative novelty of the procedure and the resulting paucity of data render conclusions respecting these matters tentative, at present the following may be stated. The accumulated evidence suggests that the risk to the woman is minimal, and well within an acceptable range. With respect to unborn children, however, it has been stated that *in vitro* fertilization involves a "higher rate of early embryonic death".[48] In relation to induced congenital abnormality, it has been concluded that "there is no dramatic positive evidence reported for IVF-mediated damage to more than 100 children estimated to have been born to date".[49]

The practice of *in vitro* fertilization raises certain additional issues. Particularly important is the general question of the status of the fertilized ovum before it is implanted in the uterus. Embraced within this question are issues respecting the implantation of mutiple ova and the propriety of scientific research involving a fertilized ovum outside the body. Recently, the Council of The Society of Obstetricians and Gynaecologists of Canada has approved a "Statement on In-Vitro Fertilization and Embryo-Transfer",[50] prepared by the Committee on Endocrinology and Fertility, which sets out guidelines for *in vitro* fertilization and addresses certain ethical issues.[51] While this Statement affords general guidance, it does not address several difficult issues, which, in effect, are left to be resolved by the medical and scientific personnel participating in I.V.F. programmes. In the United States, The American Fertility Society has approved an ethical statement on *in vitro* fertilization and a statement suggesting minimum standards for I.V.F. programmes.[52]

---

[46] *Stedman's Medical Dictionary* (24th ed., 1982) explains (at 442) that an ectopic pregnancy is "a pregnancy occurring elsewhere than in the cavity of the uterus".

[47] See Grobstein, *supra*, note 41, at 128-29.

[48] *Ibid.*, at 128.

[49] *Ibid.*, at 128-29. In Grobstein, *ibid.*, at 128, it was reported that there has been a single abnormality — a cardiac malformation, which was subsequently corrected by surgery. However, a more recent study reports 4 birth defects in 590 I.V.F. children: 2 infants suffered from heart valve anomalies, 1 had an extra digit and 1 had trisomy 21: see Hodgen, "Summary of Current Status of *In Vitro* Fertilization and Embryo Transfer Therapy", presented to the National Academy of Sciences, Genetic Manipulation of the Human Germline Planning Group, at Helsinki, Finland (June 6, 1984).

[50] The Society of Obstetricians and Gynaecologists of Canada, "Statement on In-Vitro Fertilization and Embryo-Transfer", published in the Bulletin of the Society, Vol. VI, No. 3, May/June, 1984, at 4.

[51] For example, the Committee on Endocrinology and Fertility stated that "In-Vitro Fertilization is a recognized and acceptable form of treatment for infertility, not treatable by other means": *ibid.*, at 4. With respect to research on embryos that are not transferred, it stated that "it is considered ethically acceptable to scientifically examine conceptuses prior to the time development has reached the stage when implantation would normally occur": *ibid.*

Where donor semen or ova are used in *in vitro* fertilization, there will be the same issues relating to donor screening and selection that we have identified in connection with artificial insemination by donor.

While much of the cost of the LIFE Program is defrayed, patients must bear a certain portion of the cost personally. The costs of those features of the investigative process that are an ordinary part of infertility investigation are paid for by the Ontario Health Insurance Plan. Except in connection with this investigation, the members of the medical team donate their services without charge. However, the part of the costs peculiar to *in vitro* fertilization — for example, attributable to the services of specialized technicians and new equipment — is not reimbursed by O.H.I.P., and must be borne personally by the couple. These costs amount to approximately $1,000, exclusive of medication.

We now turn to consider a recently perfected procedure for the donation of an ovum. This procedure involves the artificial fertilization of an ovum *in vivo* in one woman and the subsequent removal of the fertilized ovum by a process called lavage, to be described below. The ovum is then transferred to the uterus of another woman. While this procedure has not yet been used in Ontario — nor, indeed, elsewhere in Canada — it has successfully achieved a birth in California. In view of the rapid advances in reproductive science that we have witnessed even in the course of this Reference, it would not be unduly speculative to imagine that this procedure will be attempted in Ontario. Consequently, we shall review the basic aspects of the procedure.

In vivo fertilization followed by lavage may be indicated where a woman who wishes to give birth to a child suffers from infertility caused by incurable ovarian problems. Genetic considerations may also favour resort to this technology; where a woman, otherwise fertile, has a genetic disease, or where genetic testing has indicated the possibility of transmitting a harmful condition, she may prefer to gestate the fertilized ovum of another woman.

The fulcrum to the success of the transfer process is to find an ovum donor whose menstrual cycles match those of the woman who is to bear the child. When testing of the prospective donor indicates that she will be ovulating approximately twenty-four hours later, semen must be provided for artificial insemination. Following artificial insemination, the fertilized ovum is allowed to develop for five days, until it consists of 80 to 100 cells.

After the five day period, the embryo is removed by a process called "lavage". This procedure involves the insertion of a catheter through the cervix and the gradual introduction of a special fluid onto the uterine walls. The embryo, which is not yet attached to the walls of the uterus, is carried by the fluid into the catheter. The fluid is then transferred to a microscope for examination in order to ensure that it contains the fertilized ovum. Once the presence of the embryo is confirmed, it is placed in a transfer medium, which is put into another catheter. By means of this catheter, the embryo is delivered through the cervix to the uterus of the recipient woman. Whether the transfer has been successful must await the results of a pregnancy test.

---

[52] See The American Fertility Society, "Ethical statement on in vitro fertilization" (1984), 41 Fertility and Sterility 12. While the ACOG Committee Statement, *supra*, note 43, issued by the Gynecologic Committee of The American College of Obstetricians and Gynecologists, discussed the technique of *in vitro* fertilization, it did not address ethical issues.

In vivo fertilization and lavage raise few legal issues that are not shared with either artificial insemination by donor or *in vitro* fertilization. As with artificial insemination by donor, the procedure involves gamete donation, which leads to questions respecting appropriate donor selection and screening. In common with *in vitro* fertilization are issues respecting the status of the fertilized ovum outside the body. What is unique to this procedure is the achievement of fertilization *in vivo*, which involves a risk of pregnancy to the intended donor should the lavage prove unsuccessful.

4. CONCLUSIONS

In this chapter, we have considered generally the incidence and causes of, and responses to, infertility in Ontario. We have seen that, while the infertility problems of many couples may be alleviated by conventional therapeutic measures, other couples are not similarly fortunate and must have recourse to alternative means of introducing a child into their lives. However, the traditional alternative, adoption, offers little real hope, owing to the scarcity of available infants. Moreover, it does not address the desire to introduce a child into the family who is related genetically to at least one parent.

Coincidental with the declining availability of infants for adoption, we have witnessed the advent and refinement of the artificial conception technologies that are the subject of this Report. These medical advances can respond effectively to the plight of many childless couples whose wishes otherwise would remain frustrated. In so doing, the artificial reproductive technologies raise novel moral, ethical, and legal issues, which the present law, conditioned to a world of natural reproduction, has yet to assimilate in a coherent fashion. How these technologies are received by the present law will be the subject of the following chapter.

CHAPTER 3

PRESENT LAW IN ONTARIO AND THE CASE FOR REFORM

1. INTRODUCTION

In previous chapters, the Commission set forth the genesis of this Project and examined the medical and related background critical to our study. We have seen that a perceived need by a significant, and growing, portion of the population has given rise to the relatively widespread use of artificial methods of conception, particularly artificial insemination. However, such use has, in turn, produced a voluble backlash from another segment of society. This reaction, while often based on fears that may not be well-founded, is nonetheless potent and worthy of deep consideration and respect. As a result, there has been a profound tension underlying the practice in this field, even though we may well be moving from "horrified negation" to "very slow but steady acceptance".[1]

In one sense, it may be argued that the law largely reflects this tension and unease. But, on another level, it seems incorrect to assume that the law has, in fact, responded to the advent of the new technologies. For the most part, silence and inadvertently or fortuitously relevant provisions pervade the "law" in this area. Of course, this state of affairs is not inherently dysfunctional or undesirable: silence may manifest a fundamental acceptance of a *laissez-faire* approach, and what may be called the unintended applicability of the law to a new area of concern may bespeak the law's capacity to grow and develop without legislative intervention. However, as we shall see in this chapter, silence and inadvertence is no substitute for a comprehensive examination of the appropriateness of the present legal rules in the context of the relatively new artificial conception technologies. These technologies have, in the main, overtaken much of a legal regime founded upon natural reproduction. And, even where there is no need for legislative reform, an analysis of the law in this area is essential in order to clarify its role.

The purpose of this chapter is to examine that part of existing law in Ontario relevant — whether intentionally so or not — to the artificial conception technologies, and to describe some of its deficiencies in relation to those technologies. We shall then conclude by stating the case for reform. From our description of the present, rather indifferent, and sometimes hostile state of the law in relation to the new technologies, we believe that the case for reform will emerge, both clearly and compellingly.

---

[1] Kleegman and Kaufman, *Infertility in Women* (1966), at 178.

For the most part, the chapter will describe the main currents of existing law applicable in Ontario; some of the details, insofar as they are relevant to a consideration of the various options for reform, await the subsequent chapter outlining our recommendations. In addition, many of the specific legal issues that the Commission will address in the later chapter will not form an essential part of the present discussion, although the existence of these issues may well be adverted to here. Rather, this chapter will deal with the law relating to certain legal questions that we regard as more or less basic to the study of artificial insemination, *in vitro* fertilization, and related matters.

For example, we shall discuss the question of eligibility for participation in an artificial conception programme and the legal status of artificially conceived children. These questions are intimately related to a central concern that animated the Attorney General in referring the Project to the Commission, namely, the "best interests" of the children conceived by means of the new technologies.

Before turning to a consideration of the eligibility of persons for participation in artificial conception programmes, we shall attempt to place the practice of artificial conception in what, at first blush at least, appears to be its fundamentally medical perspective.

2. ARTIFICIAL CONCEPTION SERVICES AS THE PRACTICE OF MEDICINE

In this section, we shall discuss whether the provision of artificial conception services constitutes the "practice of medicine" under the *Health Disciplines Act.*[2] Resolution of this apparently narrow definitional question has far-reaching practical and policy implications. Should an artificial conception procedure be regarded as the practice of medicine, conduct of the procedure would be relegated to individuals licensed to practice medicine under Part III of the Act or to persons acting under their supervision or direction. Performance of the procedure by others, therefore, would be an offence under that Act, punishable in the first instance by fine, and subsequently by fine or imprisonment, or both.[3]

As we shall see, one rationale for declaring a certain procedure to be the practice of medicine is that it helps to preclude unqualified persons from undertaking the procedure and, accordingly, serves to promote the public welfare. On the other hand, it may be argued that certain services — for example, artificial insemination — may be unavailable to some infertile persons because such services are either geographically or financially inaccessible. Consequently, unless the procedure clearly is such as to require professional medical attention for reasons of, for example, health and safety, it may be thought inadvisable to prohibit people from making their own arrangements.

---

[2] *Health Disciplines Act*, R.S.O. 1980, c. 196.

[3] *Ibid.*, ss. 52 and 67.

As we have explained earlier,[4] artificial insemination is a simpler procedure than *in vitro* fertilization; it does not demand as great an expertise, nor is the necessary apparatus as elaborate. Consequently, artificial insemination can be performed far more easily by nonmedical persons who have acquired the requisite skill and knowledge; indeed, there have been accounts of artificial insemination having been conducted by laypersons.[5] It is the simplicity of the procedure, and its concomitant accessibility, that as a practical matter renders the question of the status of artificial insemination a problem that we believe should be specifically addressed. The issue whether I.V.F. constitutes the practice of medicine may be less controversial since, by its very nature, it must ordinarily be performed in a clinical setting by qualified professionals. However, one need not be a physician to attain the essential skills.

Turning to the definition of the "practice of medicine" in Part III of the *Health Disciplines Act*, we observe that its very general language affords little guidance concerning its ambit. The "practice of medicine" is defined simply to include "the practice of surgery and obstetrics".[6] Prior to the enactment of *The Health Disciplines Act, 1974*,[7] except for a very brief period in the 1920's,[8] the expression "practice of medicine" was not defined. However, having regard to the extensive mandate given to the College of Physicians and Surgeons of Ontario under the *Health Disciplines Act*,[9] any determination that it might make

---

[4] See *supra*, ch. 2, sec. 3(b)(i) and (ii).

[5] See, for example, *The Toronto Star*, Toronto (April 25, 1983), at D2.

[6] *Supra*, note 2, s. 45(f).

[7] S.O. 1974, c. 47.

[8] In 1923, *The Ontario Medical Act, 1923*, S.O. 1923, c. 35, s. 2, provided as follows:

> 2. Every person shall be deemed to practise medicine within the meaning of this Act who holds himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical condition or who shall either offer or undertake by any means or method to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical condition.

This provision was repealed by *The Ontario Medical Act, 1925*, S.O. 1925, c. 48, s. 3. For a discussion of the background to these developments, see McNab, *A Legal History of the Health Profession in Ontario — A Study for the Committee on the Healing Arts* (1970), at 46-48.

[9] Section 46(2) of the *Health Disciplines Act*, *supra*, note 2, provides that it is the mandate of the College

> (a) to regulate the practice of medicine and to govern its members in accordance with this Act, the regulations and the by-laws;
>
> (b) to establish, maintain and develop standards of knowledge and skill among its members;
>
> (c) to establish, maintain and develop standards of qualification and practice for the practice of medicine;

concerning whether specific activities fall within the ambit of the practice of medicine would be particularly persuasive. In addition, the Council of the College of Physicians and Surgeons of Ontario, which is the governing body, is empowered, subject to the approval of the Lieutenant Governor in Council and with the prior review of the Minister of Health, to make regulations "governing standards of practice for the profession" and "authorizing persons other than members [of the College] to perform specified acts in the practice of medicine under the supervision or direction of a member".[10] This last provision is particularly relevant in the case of artificial insemination: even assuming that the procedure constitutes the "practice of medicine", its relative simplicity may predispose the Council to permit laypersons to perform it under a physician's "supervision or direction".

Very little attention has been given to the meaning of the term "practice of medicine" in the case law. The most comprehensive discussion of this issue can be found in *In re Ontario Medical Act.*[11] In that case, the Lieutenant Governor in Council referred to the Ontario Court of Appeal the question whether or not the words "to practise medicine" (as opposed to "surgery") in section 49 of *The Ontario Medical Act*[12] meant to attempt to cure or alleviate disease solely by the use of drugs or other similar substances.

By a majority, the Court of Appeal took the view that the expression "to practise medicine", although difficult to construe as an abstraction divorced from concrete cases, was to be regarded as a fluid concept, which should be interpreted so as to reflect advances in scientific knowledge and innovations in technique.[13] The approach of certain of the justices appeared to follow from their perception that the policy of *The Ontario Medical Act* was to protect the public

---

(d) to establish, maintain and develop standards of professional ethics among its members;

(e) to administer this Part and perform such other duties and exercise such other powers as are imposed or conferred on the College by or under any Act;

(f) such other objects relating to human health care as the Council considers desirable,

in order that the public interest may be served and protected.

With respect to by-laws that may provide for a code of ethics, see *ibid.*, s. 51(1)(k).

[10] *Ibid.*, s. 50(g) and (k).

[11] (1906), 13 O.L.R. 501 (C.A.).

[12] R.S.O. 1897, c. 176. Section 49 provided, *inter alia*, that "[i]t shall not be lawful for any person not registered to practise medicine, surgery or midwifery for hire, gain, or hope of reward", and then provided a penalty for contravention of the section. It should be noted that the present prohibition in s. 52(1) of the *Health Disciplines Act*, *supra*, note 2, makes no reference to financial or other reward.

[13] In a dissenting judgment, Mr. Justice Meredith interpreted the words "to practise medicine" in a restrictive fashion, confining its meaning to "the art of healing the sick by means of medicines or drugs": *supra*, note 11, at 519.

from unqualified persons, rather than to protect the monopoly on the provision of health care services enjoyed by the medical profession.

Having regard to the paucity of statutory or judicial guidance,[14] it cannot be stated unequivocally that artificial insemination is or is not the practice of medicine within the meaning of the *Health Disciplines Act*. It would appear, however, that if the practice of medicine, as suggested by the majority in *In re Ontario Medical Act*, were to be regarded as an elastic, rather than a static, concept, capable of expansion to accommodate innovation, artificial insemination, now a generally accepted treatment for infertility, would be within its embrace. So, too, would other artificial conception procedures, such as I.V.F., which, as we have said, demand a more sophisticated expertise.

The view that, in Ontario at least, the practice of medicine includes artificial insemination is supported by the fact that, since 1974, artificial insemination has been listed in the Schedule of Benefits under the Ontario Health Insurance Plan. Indeed, the fiscal year 1983-84, the Plan paid for almost 10,000 inseminations.[15]

Further support for the conclusion that, as a matter of law, artificial insemination would be regarded as the practice of medicine can be found by having regard to the various facets of the procedure. As we described in more detail in chapter 2, artificial insemination involves not only the intravaginal or intrauterine placement of semen, but, properly done, also involves several ancillary procedures, most of which have a decidedly medical character.

Artificial insemination is a procedure that is not without danger. There is a risk of infection and a risk of penetration of the cervix. The injection of semen into the uterus could cause a severe reaction, and possibly death. Complications may also arise from the injection of air. That these risks are associated with the procedure favours restricting its performance to individuals with assured knowledge and technical expertise, and militates against leaving it to the untutored or inexperienced. However, it does bear repeating that, even if the procedure were declared to be the practice of medicine, it would still be possible to make regulations permitting laypersons to perform the procedure themselves, so long as they did so under the "supervision or direction" of a doctor.

---

[14] In *R. v. Wong*, [1979] 6 W.W.R. 163 (Alta. Prov. Ct.), the accused acupuncturist had been charged with unlawfully practising medicine in violation of the Alberta *Medical Profession Act, 1975*, S.A. 1975, c. 26, s. 64(1)(a). In finding the accused not guilty, Stevenson Prov. Ct. J. took the view that the prime object of the legislation was "the protection of the monopoly of practising, and not the protection of the public against the quacks or unregistered" (at 168-70, quoting Garrow J.A. in *In re Ontario Medical Act*, *supra*, note 11, at 511-12). Further, he held that the words "to practise medicine" should be strictly interpreted in the context of s. 64.

After reviewing the interpretation given to the term "practice of medicine" in previous decisions, including *In re Ontario Medical Act*, Stevenson Prov. Ct. J. observed that, "[i]nsofar as the evidence discloses, it [acupuncture] is not recognized by the Alberta College of Physicians and Surgeons as a branch of 'medicine', nor is it taught as an approved course of medical education at any university in North America" (at 174).

Other cases have been concerned with whether the number of the impugned acts was sufficient to constitute the practice of medicine: see, for example, *R. v. Whelan* (1900), 4 C.C.C. 277 (Ont. Co. Ct.); *R. v. Cruikshanks* (1914), 7 Alta. L.R. 92, 16 D.L.R. 536 (S.C.); and *R. v. Armstrong* (1911), 18 C.C.C. 72 (Sask. Pol. Ct.).

[15] See *supra*, ch. 2, note 26. See, also, Ontario, Ministry of Health, *Ontario Health Insurance Plan, Schedule of Benefits — Physician Services* (April 1, 1984). Artificial insemination is classified as Code Item G367 under the rubric of Gynaecology in Diagnostic and Therapeutic Procedures.

Turning to the question whether I.V.F. constitutes the practice of medicine, we have seen that, even more than artificial insemination, I.V.F. is dependent upon scientific processes. The technique of acquiring ova by laparoscopy, the fertilization of the ova *in vitro*, and the placement of such ova in the uterus, as well as cryostoring gametes, are highly technical procedures.

The continuing experimentation in respect of I.V.F. — or, to put it another way, the only very recent application of I.V.F. to circumvent infertility in humans — does not, in itself, conclusively establish that it is not the practice of medicine. Moreover, the fact that professionals other than doctors are involved in such procedures is no more determinative of the status of I.V.F. than is the fact that laypersons can perform artificial insemination.[16]

One commentator suggested in 1975 that, while I.V.F. is still experimental in nature, it may be more apt to call it therapeutic innovation rather than pure experimentation.[17] Medicine, and particularly I.V.F., have come quite some distance since 1975. As we have seen from the majority decision in the *In re Ontario Medical Act* case,[18] the concept of the practice of medicine should be regarded as an expanding and flexible one, having regard to continuing advances in the discipline.[19]

Moreover, experimentation itself is hardly unique to I.V.F.: it clearly is involved in a very great deal of the more traditional "practice of medicine". While, then, the experimental portion of I.V.F. may well bring together professionals from several disciplines, it is not unreasonable to suggest that, to the extent that the existing procedure is designed and actually used to treat infertility, it is the practice of medicine, or has a dominant practice of medicine component.

To this point, we have considered the question whether artificial conception services as such constitute the practice of medicine. As indicated in the preceding paragraph, we have more or less assumed that these procedures would be used to circumvent the problem of infertility. But the question discussed here cannot be considered exclusively from the standpoint of whether artificial insemination and I.V.F. are somehow inherently medical procedures that should be performed only by doctors.

---

[16] The fact that I.V.F. has not been listed in the O.H.I.P. Schedule of Benefits is also not conclusive. There may be several reasons for its exclusion, including, perhaps, its relative novelty. Indeed, not all procedures that are clearly medical are covered by the Plan.

[17] See Dickens, "What is a medical experiment?" (1975), 113 Can. Med. Ass'n J. 635.

[18] *Supra*, note 11.

[19] The Committee on Endocrinology and Fertility of The Society of Obstetricians and Gynaecologists of Canada has stated that I.V.F. "is a recognized and acceptable form of treatment for infertility, not treatable by other means": "Statement on In-Vitro Fertilization and Embryo-Transfer", published in the Society's Bulletin, Vol. VI, No. 3, May/June, 1984, at 4.

It will be recalled that a further issue arising from *In re Ontario Medical Act* concerned the underlying basic assumption that the practice of medicine is designed to alleviate "disease". We raise this matter not because we believe that infertility is not a disease.[20] Rather, the issue may prompt ethical and philosophical questions concerning the role of artificial conception technology and of doctors where the treatment is not, in fact, intended to circumvent problems of infertility. For example, an unmarried woman without a male partner may seek A.I.D., or a woman may wish to use the services of a surrogate mother simply to avoid the inconvenience or risk of pregnancy. The focus, in the Court of Appeal, on the practice of medicine as the cure or alleviation of disease may serve, then, to put this type of use of artificial conception into a somewhat different, not purely medical, perspective. It may perhaps be argued that, to the extent that artificial conception is used notwithstanding the absence of infertility or genetic impairment, it is not in fact the practice of medicine relegated to the medical profession.

At the beginning of this section, we noted that one reason for expressly declaring artificial conception procedures to be the "practice of medicine" is that, by bringing the procedures under the *Health Disciplines Act*, unqualified people would be precluded from offering and undertaking such procedures. In other words, a declaration of the kind just described would promote public health and welfare.

The Commission acknowledges the fact that artificial conception services may be difficult to obtain for some persons who live far from an appropriately trained medical practitioner and who cannot afford to travel the distance for such services. However, we have concluded that the need to protect the public, by ensuring the provision of adequate health care, is a compelling justification for expressly limiting all types of artificial conception procedures to physicians.

The notion that legislation designating artificial conception procedures to be the "practice of medicine" is to protect the public from the dangers arising from unqualified persons performing such procedures may, at first blush, seem not to carry the same weight in the context of artificial insemination as it does in the context of I.V.F., having regard to the relative simplicity of the former type of procedure. However, paradoxically, its very simplicity may well give rise to the need for greater care: the temptation of laypersons to perform the procedure without any medical assistance or direction is presumably stronger in the case of artificial insemination. Accordingly, it is not unreasonable to speculate that the medical complications that may arise in artificial insemination are less likely to be prevented, detected, or treated where only laypersons are involved.

---

[20] See the discussion, *infra*, this ch., sec. (3)(b)(ii), concerning whether infertility is a "handicap" under the Ontario *Human Rights Code, 1981*, S.O. 1981, c. 53. See, also, Queensland, *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters* (1984) (hereinafter referred to as "Queensland Report"), at 17, where it was noted that some written submissions challenged the assertion that infertility is a disease.

We do recognize, of course, that the very factors that would leave open the potential for such adverse medical consequences in the case of artificial insemination — that is, the general ease of application and, therefore, the increased likelihood of its use by untutored laypersons — also militate against the efficacy of declaring the procedure to be the practice of medicine: clandestine performance of the procedure would be difficult to detect, thereby reducing the significance of any sanctions that might be imposed on a layperson for carrying out the practice. However, we are firmly of the view that the possibility of occasional surreptitious performance of artificial insemination by nonmedical persons ought not to govern what we believe to be necessary law reform in the public interest.

The same view applies to the practice of I.V.F., although, as we have indicated, the greater complexity of the I.V.F. procedure seems much more likely to assure a proper measure of medical control at the present time. But, as in the case of artificial insemination, we believe the applicability of legislation, regulations, and ethical codes governing doctors should not be left to conjecture. Rather, legislation should be enacted to clarify what we see as the unique and exclusive role of the medical profession in the provision of artificial conception services.

3. ELIGIBILITY TO PARTICIPATE IN ARTIFICIAL CONCEPTION PROGRAMMES

In this section, we shall discuss the law respecting participation in artificial conception programmes. Is there a legal right to parenthood? May legislation prohibit access to artificial insemination or I.V.F. programmes or discriminate among potential participants? What avenues, if any, are open to persons denied access to artificial conception technologies by individual physicians or hospitals?

(a) INTERNATIONAL PROVISIONS

Where nature presents barriers to the conception of a child, any claim to a legal right to parenthood would have seemed, at one time, to be rather academic. Yet, as we have seen, the ability of medicine to circumvent the consequences of infertility has given new force to this issue.

Indeed, the right to remain free to found a family has achieved wide recognition, and has received strong legal and moral support at international and national levels. Further, while nature may seem to distinguish between the reproductively capable and the reproductively incapable or less capable, legal discrimination on grounds of disability or handicap is becoming increasingly proscribed.

The 1948 Universal Declaration of Human Rights, proclaimed by the United Nations, recognizes the right of everyone to have children. However, this right is rather amorphously worded and, perhaps, may have been imperfectly constituted if the intention was to achieve maximum amelioration in law of the plight of infertile couples: while the Universal Declaration may protect reproductive initiatives of competent persons who are fertile, it appears to oblige no person, organization, or government to offer services to the infertile.

The Universal Declaration has been given more specific effect and a potential for enforceability through two covenants, namely, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights, both of which came into force in 1976 and have been ratified by Canada. It is significant that Canada has also subscribed to an optional protocol to the International Covenant on Civil and Political Rights, which allows Canadian nationals to complain of alleged violations committed in Canada. The United Nations Human Rights Committee, which administers the Covenant, may then investigate the allegations, record findings, and initiate remedies.

The Covenant on Economic, Social and Cultural Rights provides in Article 2 as follows:

> 1. Each State Party to the present Covenant undertakes to take steps … with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

Article 10 provides:

> The States Parties to the present Covenant recognize that:
>
> 1. The widest possible protection and assistance should be accorded to the family … particularly for its establishment….

Article 15 provides:

> 1. The States Parties to the present Covenant recognize the right of everyone: … (b) To enjoy the benefits of scientific progress and its applications….
>
> 3. The States Parties to the present Covenant undertake to respect the freedom indispensable for scientific research and creative activity.

Taken together, these provisions may require ratifying States to protect the establishment of families, by legislation if possible and necessary, and to afford individuals access to such "benefits of scientific progress and its applications" as artificial means of conception, or at least not to deny that access where it is available. In Canada, provincial health facilities include infertility services, provincial health insurance plans accommodate artificial insemination, and several centres have recently established I.V.F. programmes. It may appear anomalous that such services are available, but with no specific legislation governing their functions and access to them by members of the community.

The other relevant international covenant that Canada has ratified is the International Covenant on Civil and Political Rights. Article 23 of the Covenant provides as follows:

> 1. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.
> 2. The right of men and women of marriageable age to marry and to found a family shall be recognized.

Article 2 of the Covenant requires States to undertake to respect the rights recognized in the Covenant "without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".

If access to means of artificial conception were offered or permitted on a restricted basis, this might raise legal questions under the International Covenant on Civil and Political Rights. As indicated above, because Canada has subscribed to the optional protocol to the Covenant, Canadian nationals may take the matter to the United Nations Human Rights Committee.

It is unclear, however, whether marital status or, for instance, sexual orientation are precluded grounds of discrimination under Article 23. The language of this provision may suggest that marriage is a legitimate precondition of the exercise of the right to found a family, consistent with the social significance of the family. It may also indicate that married persons may require that they be afforded access to artificial insemination and I.V.F. However, it is not clear that they may be protected where, in attempting to found a family, they involve a third person who, for example, agrees to donate gametes.

The general unenforceability of the international legal order presents a serious dilemma. The gap between subscribing to high principles and the actual conduct of States can only infrequently be narrowed by resort to international legal agencies and tribunals, since these bodies lack compulsory jurisdiction. Moreover, it is uncertain whether Canadian courts would give effect to the international undertakings described above in the course of domestic litigation.

While, in a federal state, the national authority that adheres to an international agreement has a legal obligation to act in good faith in exercising power to enact compatible national provisions, it is for the constituent governments to decide whether to pass legislation that would implement treaties covering matters within their exclusive jurisdiction.[21] In some cases, federal and provincial statutes may be interpreted so as to make them compatible with international obligations. But the federal government lacks legal means to compel the provinces to enact legislation consistent with international undertakings entered into by the federal government.

---

[21] See Hogg, *Constitutional Law of Canada* (1977), at 185. See, also, *A.G.-Can. v. A.-G. Ont.* (Labour Conventions), [1937] A.C. 326, discussed in Hogg, at 189-90.

(b) NATIONAL PROVISIONS RELATING TO DISCRIMINATION AND CIVIL RIGHTS

We now turn to national legislative provisions relating to discrimination and civil rights — provisions that have far more impact on the issue under discussion than international law and conventions. The *Canadian Charter of Rights and Freedoms*[22] and the Ontario *Human Rights Code, 1981*[23] raise two separate and distinct issues relating to access to the new reproductive technologies under consideration. The first issue is whether legislation or the private actions of individuals that would preclude resort to all or any of these technologies would contravene the rights and freedoms guaranteed by the Charter or the Ontario *Human Rights Code, 1981*. The second issue is whether legislation or private conduct could discriminate among potential beneficiaries of these technologies where all or any of the artificial conception technologies are being practised. For example, it must be asked whether resort to the technologies could lawfully be restricted to married couples.

(i) *Canadian Charter of Rights and Freedoms*

a. General

Prior to outlining the Charter's possible effect on legislation and individual actions respecting the provision of artificial conception services and access to such services, a general overview of the Charter is in order.

First, regarding the applicability of the Charter, section 32(1) reads:

> 32.-(1) This Charter applies
>
> (a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and
>
> (b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

There would seem to be general agreement that the effect of section 32(1)(b) is to make the Charter applicable to all laws within the authority of the legislature of a province.[24] Moreover, it has been suggested that, as a result of section 52(1) of the *Constitution Act, 1982*, the Charter goes further by invalidating laws that are inconsistent with its provisions. Section 52(1) provides as follows:

---

[22] *Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, which is itself Schedule B of the *Canada Act 1982*, c. 11 (U.K.).

[23] *Supra*, note 20.

[24] See, for example, Swinton, "Application of the Canadian Charter of Rights and Freedoms", in Tarnopolsky and Beaudoin (eds.), *Canadian Charter of Rights and Freedoms: Commentary* (1982) 41, at 49, and Gibson, "Distinguishing the Governors from the Governed: The Meaning of 'Government' under Section 32(1) of the Charter" (1983), 13 Man. L.J. 505. Compare Manning, *Rights, Freedoms and the Courts* (1983).

> 52.-(1) The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

While, having regard to section 32(1) alone, it might appear that the applicability of the Charter is restricted exclusively to acts of legislative bodies, the reference in section 52(1) to "any law" seems to expand the application of the Charter to, for example, the common law.[25]

For our purposes, more critical than the applicability of the Charter to common law rules is the question whether the Charter may be used to challenge private conduct, as opposed to legislative measures. For example, could the Charter be used where a physician or fertility clinic denies access to artificial conception services to unmarried women?

While clearly the law respecting the Charter is evolving, the weight of opinion at present appears to be that the Charter cannot be successfully invoked to invalidate private conduct. This view is founded essentially on the language of section 32(1), although it may be said that section 52(1) does not detract at all from this argument.[26]

A more difficult question concerns the applicability of the Charter to, for example, restrictive or prohibitory rules established by public hospitals. Since the Charter applies to governmental bodies, the answer depends on whether public hospitals are to be regarded as agencies of the Crown. In this connection, it should be noted that no place may be operated or used for the purposes of a hospital without the approval of the Lieutenant Governor in Council, on the recommendation of the Minister of Health.[27] Moreover, a hospital is authorized by the *Public Hospitals Act* to pass by-laws, subject to the Minister's approval.[28] Such by-laws may provide, for example, for the appointment of a medical advisory committee, which must make recommendations to the hospital board respecting, *inter alia*, the quality of medical care provided, and must supervise the practice of medicine in the hospital.[29] In short, leaving aside the creation of public hospitals, the functioning of such hospitals clearly has a public, governmental aspect to it, not so much in the daily operation of the institutions as in the statutory authority to pass by-laws and the accountability of the hospitals to the Minister of Health.

---

[25] See, for example, Pratt, "The Charter and How to Approach it: A Guide for the Civil Practitioner" (1983), 4 Advocates' Q. 425, and Gibson, *supra*, note 24, at 514.

[26] See Swinton, *supra*, note 24, at 49. But see Gibson, "The Charter of Rights and the Private Sector" (1982), 12 Man. L.J. 213.

[27] *Public Hospitals Act*, R.S.O. 1980, c. 410, s. 4(2).

[28] *Ibid.*, s. 9(1).

[29] R.R.O. 1980, Reg. 865, s. 7(1) and (6).

Having regard, then, to the likely purpose of the Charter — to protect individuals from actions of the organs of government that infringe certain rights — and to the intimate nexus between the government and the rules governing the creation, operation, and funding of public hospitals, it may be suggested that actions by public hospitals that infringe the fundamental rights and freedoms enshrined in the Charter may be challenged under the latter legislation. Again, section 32(1) provides that the Charter comprehends "all matters within the authority of the legislature of each province", and section 52(1) invalidates "any law" that is inconsistent with the Charter: there seems to be no reason to restrict these sections to statutes and regulations passed by legislatures.[30] While there certainly are many grey areas concerning the ambit of the phrases just quoted, the nature and extent of ministerial control over public hospitals argues in favour of the above proposition.[31]

We turn now to consider the specific fundamental rights and freedoms guaranteed by the Charter. The first point to bear in mind is that the rights and freedoms described in sections 7 to 15 are not absolute. Rather, under section 1 of the Charter, it is made clear that these rights and freedoms are guaranteed "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".

It is also important to note that these rights and freedoms are subject to the *non obstante* clause in the Charter. Section 33(1) of the Charter states that "Parliament or the legislature of a province may expressly declare in an Act of Parliament or of the legislature, as the case may be, that the Act or a provision thereof shall operate notwithstanding a provision included in section 2 or sections 7 to 15 of this Charter".

Where there has been a violation of any of the rights or freedoms guaranteed by the Charter, under section 24(1) the injured party "may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances". In addition, as we have noted, section 52 of the *Constitution Act, 1982* provides that any law that is inconsistent with the provisions of the Constitution (including the *Canadian Charter of Rights and Freedoms)* is, "to the extent of the inconsistency, of no force or effect".

b. The Prohibition of Artificial Conception Technologies: Is There a Right to Procreate?

As with many questions concerning the Charter, no definitive answer can be given to the question whether it guarantees a right to procreate; clearly, the Charter makes no specific mention of such a right. While section 26 of the

---

[30] See, generally, abstracts of Charter decisions respecting s. 32, in Laskin *et al*. (eds.), *The Canadian Charter of Rights Annotated* (1984), at 27-4 *et seq*.

[31] See Swinton, *supra*, note 24, at 49-59. See, also, Gibson, *supra*, note 24, at 517, where the author notes, in the course of argument, the " 'governmental' quality" of public hospitals.

Charter states that the guarantee of certain rights and freedoms by specific Charter provisions "shall not be construed as denying the existence of any other rights or freedoms that exist in Canada", it appears appropriate to look primarily to section 7 for the basis of any procreative right. Section 7 provides:

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Having regard to the language of section 7, it is useful to look to American constitutional law for some possible guidance concerning its scope and meaning. Over the last half century, the Supreme Court of the United States has evolved a qualified, constitutionally-based fundamental right of privacy,[32] which includes, *inter alia,* the right to procreate.[33] The right of privacy is based on the American equivalent of section 7 of the Charter — the due process clause — and a number of other Amendments to the United States Constitution. This right has manifested itself in various settings, in which the Supreme Court of the United States has held unconstitutional legislation requiring sterilization of some criminals,[34] prohibiting or restricting the availability of contraceptives,[35] and prohibiting abortions in the first trimester of pregnancy.[36]

Section 7 of the Charter does not expressly comprehend a right to procreate. But can it be said that section 7 may give rise to a broadly based right to privacy — a right that would include a right to procreate? In *The Queen v. Morgentaler,*[37] Parker A.C.J.H.C. discussed, *inter alia,* two models of interpretation respecting section 7.[38] One model views the provision as dealing narrowly with freedom from arrest and detention and protection from arbitrary interference with liberty. The second, broader model, which His Lordship favoured, sees section 7 "as providing broad protections for the individual against government interference, protections which permit substantive review of a wide variety of laws that purport to infringe or breach the privacy of the individual".[39] He went on to say that, "[u]nder this model, the word 'liberty' would include reproductive liberty ...".[40] At a later juncture, Parker A.C.J.H.C. returned briefly, and only in passing, to this theme:[41]

---

[32] See, for example, *Griswold v. Connecticut,* 381 U.S. 479 (1965), and cases following it. Under American constitutional law, legislation interfering with a "fundamental right" — such as the right to privacy — would be upheld only if there was a "compelling state interest" served by the legislation: see Tribe, *American Constitutional Law* (1978), esp. at 1000-12, and 1019.

[33] See, for example, *Skinner v. Oklahoma,* 316 U.S. 535 (1942). Compare *Buck v. Bell,* 274 U.S. 200 (1927).

[34] *Ibid.*

[35] *Griswold v. Connecticut, supra,* note 32; *Eisenstadt v. Baird,* 405 U.S. 438 (1971); *Carey v. Population Services,* 431 U.S. 678 (1977); and *Bolger v. Youngs Drug Products,* 103 S. Ct. 2875 (1983).

[36] *Roe v. Wade,* 410 U.S. 113 (1973); *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976); *Belotti v. Baird,* 428 U.S. 132 (1976); *Belotti v. Baird II,* 443 U.S. 622 (1979); and *City of Akron v. Akron Reproductive Health Inc.,* 103 S. Ct. 2481 (1983).

[37] (1984), 47 O.R. (2d) 353 (H.C.J.).

[38] *Ibid.,* at 394 *et seq.*

> This analysis would support the proposition that certain elements of the right to privacy may be protected by s. 7 of the *Charter*. The decision to marry and to have children might be granted constitutional protection because they are considered deeply rooted in our traditions, and fundamental to our way of life.

Since, however, the right to procreate was not in issue in the case, His Lordship did not elaborate on the point.

If, then, Canadian courts were prepared to read into the *Canadian Charter of Rights and Freedoms* a right to privacy, it might perhaps be argued that prohibiting resort to reproductive technologies in the case of infertile couples would be a violation of that right and, therefore, a contravention of the Charter. A comparable argument may be made regarding those whose natural reproduction would expose their children to the risk of transmission of deleterious genes.

But even if section 7 were interpreted to give rise to a right to procreate, it might be advanced that it guarantees only that the "right to life, liberty and security of the person" will not be denied without procedural due process. Accordingly, legislation prohibiting resort to the technologies altogether may not result in any infringement of any right enjoyed by virtue of section 7. In other words, it would be argued that, while section 7 guarantees procedural due process, it does not guarantee substantive due process, thereby denying to the courts under that provision the right to adjudge the reasonableness of the legislation. It should be pointed out, however, that in a number of cases courts have held that section 7 does, in fact, guarantee both procedural and substantive due process.[42]

In addition to relying on section 7 to dispute the constitutional validity of legislation prohibiting resort to the reproductive technologies under discussion, it may also be possible to found an argument to the same effect based on section 15 of the Charter, which will come into force on April 17, 1985. Section 15(1) of the Charter states as follows:

> 15.-(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in

---

[39] *Ibid.*, at 394-95.

[40] *Ibid.*, at 395.

[41] *Ibid.*, at 407.

[42] See, for example, *Reference re S. 94(2) of the Motor Vehicle Act (B.C.)* (1983), 42 B.C.L.R. 364, 147 D.L.R. (3d) 539 (C.A.), and *R. v. Carriere* (1983), 2 C.R.D. 850.60-10 (Ont. Prov. Ct. (C.D.)). Compare, for example, *Re Jamieson and the Queen* (1982), 70 C.C.C. (2d) 430, 142 D.L.R. (3d) 54 (Que. S.C.), and *R. v. Holman* (1982), 28 C.R. (3d) 378, 16 M.V.R. 225 (B.C. Prov. Ct.), aff'd on other grounds (1982), 2 C.C.C. (3d) 19, 143 D.L.R. (3d) 748 (B.C.S.C.).

> particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

It might be contended that, if a right to procreate exists, for example under section 7 of the Charter, this right can be guaranteed to the infertile only if they are provided with equal opportunity, having regard to their physical disability. Thus, if the Charter guarantees a right to procreate to all, that right can be enjoyed by infertile couples only if the law does not impose any obstacles to the use of the new technologies.

One answer to this argument may be that, indeed, all citizens would be treated equally under a law that prohibits any resort to reproductive technologies. Both those who are fertile and those who are infertile would enjoy the same right or, rather, lack thereof, to the technologies. It may be granted that such a law would leave those who are fertile to their own devices, while potentially condemning the infertile to a childless future. Moreover, fertile couples seeking to avoid the transmission of genetic diseases by the use of artificial conception would also fall prey to the prohibition. However, the result would be no different in the case of any biological disadvantage that could be ameliorated only by certain allegedly undesirable practices outlawed by legislation.

State sanctioning of the technologies without any funding of resort to them may give rise to another section 15 line of argument. It may be contended that such an approach would discriminate against the infertile, at least in result: the state would be allocating resources for childbirth for the fertile, while denying resources to conceive in the case of the infertile, who, by definition, could not make use of state-supported childbirth facilities. Such a denial could be tantamount to prohibition for persons without adequate financial resources.

A somewhat similar problem has been considered by the United States Supreme Court. In *Harris v. McRae* [43] and *Williams v. Zbaraz*,[44] the Court held that the government's failure to provide Medicaid for medically necessary abortions did not violate the due process clause of the American Constitution. The Court stated that the right to an abortion in the first trimester of pregnancy, enunciated by the Supreme Court in *Roe v. Wade*,[45] was not infringed. All women were entitled to that right, but, as the Court in *Harris* said,[46] that right did not afford them

> a constitutional entitlement to the financial resources to avail [themselves] of the full range of protected choices. The reason why was explained in [*Maher v. Roe*[47]]: although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category.

---

[43] 448 U.S. 297, 100 S. Ct. 2671 (1980) (subsequent reference is to 448 U.S.).

[44] 448 U.S. 358, 100 S. Ct. 2694 (1980).

[45] *Supra*, note 36.

[46] *Supra*, note 43, at 316.

[47] 432 U.S. 464 (1977).

Arguably, infertility also falls into the latter category and, although the Province perhaps cannot impede the enjoyment of the right to procreate, it need not facilitate access to the means to procreate.

It should be pointed out that the reasoning of the Supreme Court of the United States in the abortion funding cases has been criticized by some commentators. One of the grounds of criticism concerns the Court's opinion that the failure to fund medically necessary abortions did not create an obstacle to the right to an abortion, recognized by *Roe v. Wade*. It has been suggested by some that the government's allocation of resources was unconstitutional because it made a constitutionally forbidden classification: that is to say, the conferment of benefits for medically necessary procedures stopped at abortion. While the Court justified the line-drawing exercise on the basis of the state's interest in potential life, the critics argue that *Roe v. Wade* had rejected this rationale as the basis for restricting the right to an abortion in the first trimester of pregnancy.[48]

When we come to deal with the relevance of the Ontario *Human Rights Code, 1981*,[49] we shall consider the extent to which "constructive", unintended discrimination — discrimination arising from the effect of certain otherwise neutral actions — may be impugnable under the Code. While, unlike the Code, the Charter contains no provision directly relevant to this issue, the matter of constructive discrimination through the outright prohibition of artificial conception services at least ought to be mentioned in the present context. It remains to be seen whether and, if so, the extent to which, this issue will become relevant in Charter litigation.

Before we leave the issue concerning whether the Charter guarantees a right to procreate, we wish to emphasize again the limitation on the rights and freedoms enunciated by the Charter. As we have seen, section 1 provides that these rights and freedoms are guaranteed subject to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society". Accordingly, it might be argued that a total prohibition of resort to the new reproductive technologies is a reasonable and justifiable limit placed on any right to procreate, on the basis, for example, that all artificial means of conception are ethically unacceptable or, perhaps in the case of I.V.F. or *in vivo* fertilization and lavage, too fraught with medical risks.

c. Discrimination in Access to the Reproductive Technologies

Assuming that legislation was enacted sanctioning resort to the reproductive technologies under discussion, and that financial resources were allocated for their availability, a discrete question arises concerning the constitutionality of restricting the technologies to certain categories of persons. For example, would it be valid to deny access to the technologies to a single person or a person living in an unmarried union?

---

[48] See, for example, Goldstein, "A Critique of the Abortion Funding Decisions: On Private Rights in the Public Sector" (1981), 8 Hastings Const. L.Q. 313.

[49] *Supra*, note 20.

Restrictive legislation, it may be argued, interferes with the right to procreate (assuming such a right exists) and, therefore, should be declared invalid under section 52 of the *Constitution Act, 1982*. This line of argument would be similar to that described above in the case of a total prohibition against resort to the technologies. In addition, a single person or an unmarried couple might claim that the kind of legislation under discussion here would contravene section 15 of the Charter when it comes into force.[50] Although section 15 does not refer specifically to marital status, it would appear to be generally accepted that the classes outlined in section 15 are not exhaustive. This is apparent from the very language of section 15, which sets out a general right and then particularizes it.

As in the case of a total prohibition of artificial conception services, it is important to bear in mind section 1 of the Charter when attempting to assess its impact. It will be recalled that this provision permits reasonable and demonstrably justifiable restrictions on the rights and freedoms guaranteed by the Charter.

(ii) *Human Rights Code, 1981*

We now turn to consider the impact of the Ontario *Human Rights Code, 1981* on the issue concerning resort to reproductive technologies. Before doing so, however, a brief review of the scheme of the Code would be useful.

The Preamble of the Code provides, *inter alia*, that the Code is designed "to revise and extend the protection of human rights in Ontario". Part I of the Act sets out the prohibited categories of discrimination, while other Parts deal with interpretation and application of the Code, the Ontario Human Rights Commission (which enforces the Code), enforcement, and miscellaneous matters.

Section 8 of the Code states that "[n]o person shall infringe or do, directly or indirectly, anything that infringes a right under [Part I]". This broadly worded prohibition has both a public and a private dimension. In the first place, it relates to legislation and the conduct of public officials that might violate the anti-discrimination strictures of Part I. Section 46(1) provides that the "Act binds the Crown and every agency of the Crown", and section 46(2) states that where other legislation "purports to require or authorize conduct that is a contravention of Part I, this Act applies and prevails unless the Act or regulation specifically provides that it is to apply notwithstanding this Act".

But the prohibition in section 8 extends beyond legislation and the activities of the Crown and its agencies. The Code also provides a means by which an individual may seek redress in respect of the private conduct of persons or institutions where he believes that a right under the Code has been infringed. Accordingly, an attempt might be made to invoke the Code where, for example, individual physicians, hospitals, or fertility clinics seek to preclude or restrict access to artificial conception facilities by single women.

---

[50] See *supra*, this sec.

The prohibited grounds of discrimination under the Code are, therefore, the same, and equally open to challenge, whether a person's impugned acts arise from the requirements or authorization of legislation or from his own volition.

For our purposes, the provision most relevant in connection with the prohibition of, or discrimination in access to, artificial conception services is section 1. This provision reads as follows:

> 1. Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, age, marital status, family status or handicap.

Unlike section 15 of the Charter, the prohibited grounds of discrimination in section 1 of the Code would seem to be exhaustive, although each ground is open to a broad or narrow interpretation.

In determining the scope of section 1, reference must be made to the definitions of some of the terms in that section. We deal first with the prohibited grounds of discrimination. Section 9(b), for example, defines "because of handicap". This term would apparently be broad enough to comprehend infertility, since the definition refers to "any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness ...". The term "family status", while at first glance apparently relevant to the present discussion, is defined to mean "the status of being in a parent and child relationship";[51] accordingly, it would not seem to be applicable to the problem of infertility.

The prohibition against discrimination on the basis of "sex" might also appear to be relevant. Could it be argued, for example, that discrimination respecting the use of artificial conception services by lesbians would violate the strictures of the Code? In this connection, however, it should be noted that discrimination because of sexual orientation has yet to be comprehended by a provision like section 1.[52]

Reference should also be made to the definition of "equal" in the Code. Section 9(c) provides that "equal" means "subject to all requirements, qualifications and considerations that are not a prohibited ground of discrimination". Section 10 is also relevant to the notion of equality and discrimination. Section 10 states:

---

[51] *Supra*, note 20, s. 9(d).

[52] See *Re University of Saskatchewan Board of Governors and Saskatchewan Human Rights Commission*, [1976] 3 W.W.R. 385, 66 D.L.R. (3d) 561 (Sask. Q.B.), and *Gay Alliance Toward Equality v. Vancouver Sun*, [1977], 5 W.W.R. 198, 77 D.L.R. (3d) 487 (B.C.C.A.), aff'd (1979), 10 B.C.L.R. 257, [1979] 2 S.C.R. 435. See, also, Keene, *Human Rights in Ontario* (1983), at 66.

> 10. A right of a person under Part I is infringed where a requirement, qualification or consideration is imposed that is not discrimination on a prohibited ground but that would result in the exclusion, qualification or preference of a group of persons who are identified by a prohibited ground of discrimination and of whom the person is a member, except where,
>
> (a) the requirement, qualification or consideration is a reasonable and *bona fide* one in the circumstances; or
>
> (b) it is declared in this Act that to discriminate because of such ground is not an infringement of a right.

Section 10 is of critical importance. Leaving aside the exceptions in clauses (a) and (b), this provision recognizes that, in some cases, treating people in the same manner can have the effect of discriminating against certain persons on a prohibited ground. Section 10, then, goes beyond intentional discrimination and applies to unintended, or constructive, discrimination: even a neutral act, without malice against the person prejudiced by that act, may come within the ambit of the section.[53]

It should be pointed out that the right to equal treatment in the case of the handicapped is not absolute. This right is restricted by section 16(1) of the Code, which provides:

> 16.-(1) A right of a person under this Act is not infringed for the reason only,
>
> (a) that the person does not have access to premises, services, goods, facilities or accommodation because of handicap, or that the premises, services, goods, facilities or accommodation lack the amenities that are appropriate for the person because of handicap; or
>
> (b) that the person is incapable of performing or fulfilling the essential duties or requirements attending the exercise of the right because of handicap.

We now turn to the implications of the Code for the new reproductive technologies. With respect to an outright prohibition of the reproductive technologies, it may be argued that such treatment with respect to services would not contravene section 1 of the Code because all persons in the Province would be treated equally: no one would have access to the technologies. However, such action effectively discriminates against the handicapped (the infertile and the fertile but genetically diseased) because they would be denied childbirth facilities available to others. As we have seen, section 10 prohibits "constructive" discrimination, that is, the imposition of an ostensibly non-discriminatory "requirement, qualification or consideration" that would result in the "exclusion, qualification or preference of a protected group of persons". Consequently, it is not unreasonable to suggest that a prohibition of access to artificial conception services to all persons effectively and unlawfully discriminates against infertile or genetically diseased persons.

The question of constructive discrimination also arises, as we noted in the previous section, in the context of funding. In chapter 2, we indicated that, unlike the case of artificial insemination, patients must bear certain substantial costs of an I.V.F. programme: the Ontario Health Insurance Plan does not cover expenses attributable, for example, to specialized I.V.F. technicians and equipment.[54] Moreover, I.V.F. facilities in Ontario public hospitals have been established only in Toronto, Hamilton, and London. Some may argue, then, that the government's allocation of financial resources is constructive discrimination that violates the Code, in that it effectively discriminates against the infertile or the genetically impaired who need access to artificial conception services to overcome their handicap.

---

[53] See Keene, *ibid.*, ch. 4.

Of course, clause (a) of section 10 excepts any requirement, qualification, or consideration that "is a reasonable and *bona fide* one in the circumstances". For example, a physician might seek to justify a refusal to offer services on the ground that such means of conception violates deeply held moral, ethical, or religious views.

One should also bear in mind section 16 of the Code. The effect of section 16 is to impose no affirmative obligation to provide access to services to the handicapped. It would appear that this provision is to be read restrictively, applying essentially to physical access,[55] for otherwise the anti-discrimination provision in section 1 would be rendered largely nugatory. However, if section 16 were to be interpreted broadly to comprehend all kinds of access, whether physical or otherwise, infertile or genetically impaired persons could not complain, for example, that certain Ontario Health Insurance Plan services were being denied to them because they are incapable of making use of the services as a result of their handicap.

Finally, a legislative scheme or private conduct that precludes resort to the reproductive technologies by certain individuals because of their marital status, age, or any of the other expressly prohibited grounds for discrimination, is likely to be most vulnerable to attack under the Code. For example, a physician may base his rejection of single persons on the ground that the best interests of children always and necessarily require that they be raised in a two-parent family environment, regardless of the suitability of any particular single applicant. Whatever the merits of such conduct, the denial of access to his services would be based on one of the enumerated grounds in section 1 of the Code. On the other hand, focusing on "suitability for parenthood" perhaps may not be objectionable, even where it results in the rejection of single applicants.[56]

---

[54] *Supra*, ch. 2, sec. 3(b)(ii).

[55] See, generally, Keene, *supra*, note 52, at 159-61.

[56] See Dickens, "*In Vitro* Fertilization — Legal and Ethical Issues" (1984), 61 U. Toronto Med. J. 70, at 71:

> Marriage is not a qualification *per se* for I.V.F., and accordingly refusal to serve the unmarried is not discrimination against them on grounds of their marital status. The critical criteria address the qualitative substance of relationships and stability of individual personalities rather than legal forms. Where applicants for I.V.F. are measured by indications of potential to be adequate parents, and are not rejected on impersonal grounds of marital status, physical or mental status, socioeconomic

Notwithstanding the anti-discrimination provisions of the Code, it should be borne in mind that, under section 46(2), the Legislative Assembly may legitimize other Acts or regulations violative of the Code where "the Act or regulation specifically provides that it is to apply notwithstanding [the Code]". This option, however, may well be unpalatable to the Legislature.

To give some idea of the perceived impact of the Code on the issue of eligibility, reference may be made by way of analogy to the 1983 proposals of the Ministry of Community and Social Services respecting eligiblity to adopt. The Ministry's Report, which included a background paper and a draft *Child and Family Services Act*, observed as follows:[57]

> Aside from a recognition of the changing concepts of marriage and the family, requirements imposed by Ontario's Human Rights Code have contributed to the elimination of the 'special circumstances' qualification for unmarried adoptive applicants. Hence, single applicants will be eligible for consideration as adoptive parents. It is, however, anticipated that in most cases adoption practice would continue to reflect a strong preference for a two-parent family based on consideration of the child's best interests.

The recently enacted *Child and Family Services Act, 1984*[58] does, in fact, place single, divorced, and widowed persons and couples who live together in a conjugal relationship on the same footing as married couples with respect to adoption.[59]

(iii) Conclusion

From our review of the provisions of the *Canadian Charter of Rights and Freedoms* and the *Human Rights Code, 1981*, it may be seen that there may be several avenues open to a person denied access to artificial conception services. However, one cannot easily generalize concerning the efficacy of the existing law. The likely success of such a person depends, for example, on whether all or only some persons are denied access, the manner in which certain categories of persons are selected for, or refused, treatment (whether, for instance, only married couples have access), whether the alleged discrimination is express or constructive, the ostensible justification for the prohibition or restriction, and the source of the allegedly discriminatory behaviour (express legislation or the actions of a hospital or individual doctor).

---

status, or philosophical, political, religious or other convictions, the decision is unlikely to violate legal requirements.

[57] Ontario, Ministry of Community and Social Services, *The Child and Family Services Act: Draft legislation and background paper* (November, 1983), at 136.

[58] During the final editing of this Report, the *Child and Family Services Act, 1984*, S.O. 1984, c. 55, was enacted, to come into force on a day to be named by proclamation of the Lieutenant Governor. While this Report will continue to refer to the *Child Welfare Act*, R.S.O. 1980, c. 66, reference will also be made to the *Child and Family Services Act, 1984*.

[59] *Child and Family Services Act, 1984*, *supra*, note 58, s. 140(4). See the definition of "spouse" in s. 130(1)(d). See, also, *infra*, ch. 4, note 30.

Discriminatory conduct operates on a spectrum, with certain kinds of activity — such as discrimination based on marital status or handicap — singled out as particularly offensive. However, while the refusal to grant access to artificial conception services on the ground of marital status may be most open to a successful challenge, the ability of a provincial legislature to override the key provisions of the Charter and the *Human Rights Code, 1981* should not be forgotten. Moreover, as we have seen, both the Charter and the Code contain provisions that permit those whose actions have been impugned to contest the matter by showing that, in the case of the Charter, the action in question is reasonable and justifiable in a free and democratic society, and that, in the case, for example, of section 10 of the Code, the action is reasonable and *bona fide* in the circumstances. No doubt, one of the most likely justifications for the restriction of access to the new reproductive technologies to stable couples would involve the invocation of the "best interests of the child" argument: it is certainly not unreasonable to suggest that the welfare of the child should be of paramount importance and, accordingly, that the most suitable environment for a child is in the home of a couple whose legal or *de facto* marriage is stable.

Yet, notwithstanding the possible means of escaping the invalidating provisions of existing legislation, it is clear that the advent of the Charter and the new Code has marked a turning point in anti-discrimination legislation. It is now more difficult to legitimize state and, to some extent, private discriminatory behaviour, even on the basis of some broad, general public interest.

(c) THE CANADIAN MEDICAL ASSOCIATION *CODE OF ETHICS*

As we indicated earlier, the Legislature has given the medical profession broad powers of self-government.[60] Of particular importance here is the jurisdiction given to the College of Physicians and Surgeons of Ontario under the *Health Disciplines Act* "to establish, maintain and develop standards of professional ethics among its members".[61] In addition, section 51(1)(k) of the Act provides that the Council of the College may pass by-laws "providing for a code of ethics".

At present, the College of Physicians and Surgeons of Ontario does not have a separate code of ethics governing doctors in this Province. Rather, the code to which the College subscribes has been developed by the nationwide umbrella organization, the Canadian Medical Association (C.M.A.).

While most of the principles of ethical behaviour contained in the C.M.A. *Code of Ethics*[62] are not directly relevant to the question of the establishment of, and eligibility for participation in, an artificial conception programme, several guidelines do relate to these matters. Reference may be made to the following principles:[63]

---

[60] See text accompanying notes 9 and 10, *supra*.

[61] *Health Disciplines Act*, *supra*, note 2, s. 46(2)(d).

[62] The Canadian Medical Association, *Code of Ethics* (September, 1982).

> An Ethical Physician:
>
> . . .
>
> 11. will recognize that he has a responsibility to render medical service to any person regardless of colour, religion or political belief;
>
> 12. shall, except in an emergency, have the right to refuse to accept a patient;
>
> 15. [i]n any ... situation [other than where 'he has accepted professional responsibility for an acutely-ill patient'], ... may withdraw from his responsibility for the care of any patient provided that he gives the patient adequate notice of his intention;
>
> 16. when his morality or religious conscience alone prevents him from recommending some form of therapy, ... will so acquaint the patient; ...

A few points emerge from a reading of these principles. First, aside from the general proposition that no physician can be forced to engage in a particular type of practice — for example, an obstetrician need not provide artificial conception services — paragraph 16 goes further to provide that a doctor need not recommend a particular form of "therapy", having regard to his moral or religious views. It would seem reasonable to suggest that a refusal to recommend or provide artificial conception services to unmarried women could be justified under paragraph 16[64] where the physician's moral or religious views on the birth of children within a traditional "family" (involving a married man and woman) effectively necessitate such a restriction.

Secondly, in addition to the general right not to be forced to engage in a particular field of medicine, and leaving aside the ambit of paragraph 16, it seems clear that, under the *Code of Ethics*, a physician is not ethically obligated to accept a particular person as a patient, except in the case of an emergency[65] and unless such refusal is based on the "colour, religion or political belief" of that person.[66] Nor need the physician continue to care for a patient, so long as "he gives the patient adequate notice of his intention" to discontinue his services.[67] Accordingly, the absence of an ethical injunction to continue to treat a patient might well permit a physician — at least under the C.M.A. guidelines — to refuse to allow an unmarried woman access to an artificial conception programme offered by him. However, a physician may not wish to discriminate explicitly on the basis of marital status as such. To the extent that a refusal to offer existing medical services to a particular person or couple is sought to be justified on perhaps more palatable or plausible grounds — where, for example, claims of "unsuitability for parenthood" are made — the efficacy of the *Code of Ethics* as a vehicle for redress by aggrieved persons is correspondingly diminished.[68]

---

[63] *Ibid.*, Responsibilities to the Patient, paras. 11, 12, 15, and 16.

[64] We need not consider here whether any other rule of law — such as the *Human Rights Code, 1981*, *supra*, note 20 — would be violated. For the relationship between the *Code of Ethics* and the "professional misconduct" provisions in the regulations made under the *Health Disciplines Act*, *supra*, note 2, see *infra*, this ch., sec. 3(d).

[65] *Code of Ethics*, *supra*, note 62, Responsibilities to the Patient, para. 12.

[66] *Ibid.*, para. 11.

[67] *Ibid.*, para. 15.

(d) *HEALTH DISCIPLINES ACT* AND *PUBLIC HOSPITALS ACT*

In determining whether to provide artificial conception services or whether to deny access to existing services to certain categories of persons, medical practitioners necessarily make moral, ethical, and socio-economic judgments in addition to purely medical assessments. Indeed, access may be restricted for exclusively nonmedical reasons. For example, the Commission's survey of the practice of A.I.D. in Ontario indicates that certain practitioners refuse to provide artificial insemination services to single women.[69] In addition, a doctor may provide services to participants only where their lifestyles or suitability for parenthood conform to the doctor's nonmedically based notions of acceptability. One obvious means of circumventing the doctor's refusal is to seek alternative medical services elsewhere. However, such services may not be available or desired. Accordingly, an issue is raised respecting the means that a refused applicant has to challenge or reverse a doctor's decision.

Under the *Health Disciplines Act*,[70] the Council of the College of Physicians and Surgeons of Ontario must establish, *inter alia*, a Complaints Committee and a Discipline Committee.[71] The Complaints Committee is required to "consider and investigate complaints made by members of the public ... regarding the conduct or actions of any member of the College...".[72] It may then, for example, direct all or part of the matter to the Discipline Committee[73] or take appropriate action on its own.[74]

---

[68] It bears mentioning here that the failure to observe the principles outlined in the *Code of Ethics* may well permit a member of the public to challenge the doctor's actions. For example, s. 27.32 of regulations promulgated under the *Health Disciplines Act*, *supra*, note 2, provides that "professional misconduct" means "conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional" (R.R.O. 1980, Reg. 448). As we shall see in a subsequent portion of this chapter, members of the public may lodge complaints with respect to the actions of doctors, complaints that could give rise to investigations respecting allegations of "professional misconduct": see *infra*, this ch., sec. 3(d).

With respect to whether a physician may have an ethical duty to screen potential participants in respect of their "suitability for parenthood", see Dickens, *supra*, note 56, at 70-71 (footnote reference deleted):

> Practitioners of I.V.F. may have an ethical rather than a legal responsibility to consider the potential capacity of their patients to offer future children an adequately nurturing environment. The duty exists at the level of macroethics, meaning social or group ethics, rather than of traditional microethics or ethics of individual relationships, since personal ethical duties may not be owable to unconceived children, and duties cannot obviously be owed to individuals to ensure that they are not conceived. It is not self-evident that such a macroethical duty exists, however, since in an analogous field surgeons able to restore women's capacity to conceive and bear children by microsurgical reconstruction or unblocking of the fallopian tubes are not necessarily required to enquire whether the women would make good mothers, or whether they are in stable domestic relationships.

[69] See *supra*, ch. 2, sec. 3(b)(i).

[70] *Supra*, note 2.

Where the Complaints Committee has rendered a decision, and where either the complainant or the physician is not satisfied, he may "request the [Health Disciplines] Board to review the decision...".[75] Upon receiving a record of the investigation and all other relevant documents from the Registrar of the College, "the Board shall review the decision after giving the complainant an opportunity to state his complaint and the member an opportunity to state his answer thereto, either personally, by his agent or in writing".[76] In addition, where a complaint has not been disposed of by the Committee in due time, the Board must undertake its own investigation.[77] In either case, the Board may confirm the decision, if any, of the Complaints Committee, recommend a course of action to the Committee, or require the Committee to take certain action or proceedings.[78]

As indicated above, the Complaints Committee may refer a complaint to the Discipline Committee.[79] Or a matter may be directed to the latter Committee by the Council or the Executive Committee.[80] Where the hearing before the Discipline Committee involves allegations of professional misconduct or incompetence,[81] and the Committee has found against the physician, it has power to determine the penalty[82] as provided in the Act.[83] A party to Discipline Committee proceedings — that is, the College and the physician in question[84] —

---

[71] *Ibid.*, s. 53(1)(c) and (d), respectively.

[72] *Ibid.*, s. 58(1).

[73] *Ibid.*, s. 58(2)(a).

[74] *Ibid.*, s. 58(2)(c).

[75] *Ibid.*, s. 8(2).

[76] *Ibid.*

[77] *Ibid.*, s. 9.

[78] *Ibid.*, s. 10.

[79] *Ibid.*, s. 58(2)(a).

[80] *Ibid.*, s. 59(6).

[81] See R.R.O. 1980, Reg. 448, s. 27, and *Health Disciplines Act, supra*, note 2, s. 60(3), respecting "professional misconduct", and *ibid.*, s. 60(4), respecting "incompetence". The two concepts may be linked in R.R.O. 1980, Reg. 448, s. 27.21, where "professional misconduct" is defined to mean, *inter alia*, the "failure to maintain the standard of practice of the profession".

[82] *Health Disciplines Act, supra*, note 2, s. 60(2)(d).

[83] *Ibid.*, s. 60(5).

[84] *Ibid.*, s. 12(1).

may appeal its decision or order to the Divisional Court.[85] The Court, in exercising "all powers of the [discipline] committee", may direct the Committee or the College to take certain action, and for this purpose may substitute its own opinion or refer the matter back to the Committee.[86]

Finally, it should be noted that the conduct of physicians may be investigated at the instance of the Registrar of the College of Physicians and Surgeons of Ontario where he "believes on reasonable and probable grounds that a member has committed an act of professional misconduct or incompetence" and the Registrar obtains the approval of the Executive Committee.[87] The Registrar is to report the results of the investigation to the Council, the Executive Committee, or such other Committee as he considers appropriate.[88]

The above survey relates to the institutional mechanisms by which a member of the public may attempt to seek recourse against a doctor who, for example, refuses him medical services. Would a denial of access to an artificial conception programme come within the ambit of the previously mentioned provisions of the *Health Disciplines Act?*

As we stated earlier, a physician cannot be forced to engage in a particular kind of medical practice — for example, artificial insemination or *in vitro* fertilization. It would appear that the refusal to provide such services to all persons would not, in itself, be sufficient ground to penalize a physician.[89]

The matter may well be quite different where the doctor does, in fact, have an artificial conception practice, but where he denies access to certain persons. We need not review here the effect of a denial of access that might be challenged under the *Human Rights Code, 1981*, or the *Canadian Charter of Rights and Freedoms.*[90] We shall restrict our discussion to complaints under the *Health Disciplines Act.*

We indicated above that the Discipline Committee may inquire into allegations of "professional misconduct" or "incompetence".[91] A question arises concerning whether the refusal to grant access to artificial conception services to, say, unmarried women or women whose lifestyles are not acceptable to a particular doctor, amounts to either professional misconduct or incompetence.

---

[85] *Ibid.*, s. 13(1).

[86] *Ibid.*, s. 13(2).

[87] *Ibid.*, s. 64(1).

[88] *Ibid.*, s. 64(7).

[89] See *Code of Ethics, supra*, note 62, Responsibilities to the Patient, paras. 12 and 16, reproduced at text following note 63, *supra*. Moreover, we doubt whether such refusal could be impeached under, for example, the *Human Rights Code, 1981, supra*, note 20, on the ground that, by effectively denying access to the infertile or the genetically diseased, the doctor is engaging in a prohibited form of "constructive" discrimination: see discussion of s. 10 of the Code in sec. 3(b)(ii), *supra*.

[90] See *supra*, this ch., sec. 3(b).

[91] See *Health Disciplines Act, supra*, note 2, s. 59(6). Section 58(2)(a), however, empowers the Complaints Committee to refer a matter to the Discipline Committee, and s. 60(1)(b) requires the latter Committee to "hear and determine matters referred to it under [*inter*

It would seem to be considerably easier to dismiss the notion that the refusal to which reference has just been made comes within the meaning of incompetence.[92] The question whether refusal to treat a particular person or class of person amounts to professional misconduct requires us to examine the definition of that term in regulations promulgated under the *Health Disciplines Act*.[93] Most of the acts constituting professional misconduct under section 27 of the relevant regulation are, in the main, irrelevant to the particular matter under consideration. Even the two kinds of activity that may have some relevance[94] seem to beg the critical question concerning whether a doctor must provide certain medical services, such as A.I.D. or I.V.F.

However, mention should also be made here of section 27.20 of the aforementioned regulation.[95] This provision defines "professional misconduct" to mean, *inter alia*, "contravening while engaged in the practice of medicine any federal, provincial or municipal law, regulation or rule or a by-law of a hospital designed to protect the public health".

---

alia] section 58...". These provisions do not expressly state that the matters in question must relate to allegations of professional misconduct or incompetence.

[92] See s. 60(4) of the *Health Disciplines Act*, *supra*, note 2, which provides as follows:

> 60.-(4) The Discipline Committee may find a member to be incompetent if in its opinion he has displayed in his professional care of a patient a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates he is unfit to continue in practice.

The tenor of s. 60(4) appears to relate more to the quality of medical care given than to the decision to provide that care in the first place.

[93] R.R.O. 1980, Reg. 448.

[94] See *ibid.*, s. 27.23 and s. 27.32. These provisions read:

> 27. For the purpose of Part III of the Act, 'professional misconduct' means,
>
> . . .
>
> 23. failing to continue to provide professional services to a patient until the services are no longer required or until the patient has had a reasonable opportunity to arrange for the services of another member;
>
> . . .
>
> 32. conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Quaere, however, the applicability of s. 27.23 where, for example, a woman has been receiving treatment for infertility and, after no success, is unable to obtain access to artificial conception services offered by the physician on the ground, subsequently discovered by the physician, that the woman is not married to her male partner.

[95] *Supra*, note 93.

Before leaving the topic of complaints and appeals respecting the refusal to provide artificial conception services, reference should be made to the possibility of obtaining redress through hospital authorities or the Ministry of Health. For example, section 32(1) of the *Public Hospitals Act*[96] requires every "board of directors, governors, trustees, commission or other governing body or authority of a hospital"[97] to establish a "medical advisory committee". The chief of the hospital's medical departments or medical staff may be made responsible by a hospital by-law to advise the committee "with respect to the quality of medical diagnosis, care and treatment provided to the patients and out-patients".[98] Section 31(3) provides a mechanism by which the decisions of any of the hospital's medical staff or of a clinic established in the hospital may be investigated. This provision reads as follows:

> 31.-(3) Where an officer of the medical staff who is responsible under subsection (1) or (2) becomes aware that, in his opinion a serious problem exists in the diagnosis, care or treatment of a patient or out-patient, he shall forthwith discuss the condition, diagnosis, care and treatment of the patient or out-patient with the attending physician, and, if changes in diagnosis, care or treatment satisfactory to him are not made promptly, he shall assume forthwith the duty of investigating, diagnosing, prescribing for and treating the patient or out-patient, as the case may be, and shall notify the attending physician, the administrator and, if possible, the patient or out-patient, that the member of the medical staff who was in attendance will cease forthwith to have any hospital privileges as the attending physician for the patient or out-patient.

Under the regulations, each hospital board must pass by-laws that provide, *inter alia*, that the medical advisory committee shall make recommendations to the board concerning "the quality of medical care provided in the hospital";[99] in addition, the committee must "provide supervision over the practice of medicine in the hospital",[100] and "advise the board on any matter referred to it by the board".[101]

Having regard, then, to the provisions of the *Public Hospitals Act* and the regulations promulgated thereunder, it is conceivable that an aggrieved person, denied the use of out-patient or other clinical facilities operated by a hospital, might seek a remedy from hospital authorities. While it would appear that the provisions considered above are directed more to the quality of medical care than to access to services, allegations that, for example, a fertility clinic offering an artificial conception programme has been unjustifiably discriminatory in its admissions policy might well be taken up and subsequently investigated by hospital personnel.[102]

---

[96] *Supra*, note 27.

[97] See *ibid.*, s. 1(c), defining the term "board", used in s. 32(1).

[98] *Ibid.*, s. 31(1) and (2).

[99] R.R.O. 1980, Reg. 865, s. 7(6)(a)(vii).

[100] *Ibid.*, s. 7(6)(b).

[101] *Ibid.*, s. 7(6)(c).

Of course, it must be recognized that, where the hospital itself has established a facility where access is restricted, it is unlikely that a challenge to that authority would be successful unless, perhaps, it could be shown to the hospital that the restriction, for example, violates some rule of law[103] and, therefore, ought to be abolished. A hospital's decision to refuse access to artificial conception services to persons who, in its opinion, would not appear to be able to offer the resulting child a stable environment may, as a matter of practice, be extremely difficult to challenge successfully under the procedures outlined above. At this point, then, recourse might have to be made to the Minister of Health, who has very wide-ranging powers to administer and enforce the *Health Disciplines Act*[104] and the *Public Hospitals Act*,[105] or, indeed, to the courts, if a challenge is sought to be mounted under the *Canadian Charter of Rights and Freedoms*, or to the Ontario Human Rights Commission, if there is an alleged violation of the *Human Rights Code, 1981*.[106]

In this section, we have attempted to review the means by which an applicant for artificial conception may seek redress against a doctor who has refused to provide her with such services. There are, as we have seen, institutional mechanisms to voice complaints against members of the medical profession. In some cases, a doctor with an artificial conception practice may be guilty of "professional misconduct" for refusing to treat a particular woman — where, for example, his actions could be characterized as "disgraceful, dishonourable or unprofessional".[107]

What we have not considered is the relationship between the C.M.A. *Code of Ethics* and the "professional misconduct" provisions in the regulations passed under the *Health Disciplines Act*. More specifically, for example, could a physician who has denied artificial conception services to an unmarried woman use the *Code of Ethics* as a shield or defence? Could the doctor successfully argue that he has not engaged in "unprofessional" conduct on the ground that "his morality or religious conscience alone"[108] prevents him from placing a child in an environment without two persons who are married to each other?

---

[102] In addition, some hospitals have established a separate "ombudsman's" office or complaints office to deal with complaints raised by members of the public.

[103] For example, any of the statutes or regulations under consideration in this section, or the *Human Rights Code, 1981*, *supra*, note 20, or the *Canadian Charter of Rights and Freedoms*, *supra*, note 22.

[104] *Supra*, note 2, s. 2.

[105] *Supra*, note 27, s. 3. See, also, *Ministry of Health Act*, R.S.O. 1980, c. 280, s. 3. The way in which the Minister of Health may influence the direction of health care and facilities may be gleaned from s. 6 of the *Ministry of Health Act*.

[106] See *supra*, this ch., sec. 3(b).

[107] See R.R.O. 1980, Reg. 448, s. 27.32, reproduced *supra*, note 94.

[108] *Code of Ethics*, *supra*, note 62, Responsibilities to the Patient, para. 16.

Having regard to the fact that the medical profession is empowered to make certain kinds of rules governing its members,[109] it may be contended that the C.M.A. *Code of Ethics*, to which the College of Physicians and Surgeons of Ontario subscribes, has the force of law. Arguably, it is more than simply a guide to ethical conduct developed by a national umbrella organization for doctors: it manifests the exercise of a statutory power to make rules governing professional ethics. If it is in conflict with a regulatory provision passed under the *Health Disciplines Act*, how should the conflict be resolved? Do the regulations somehow set forth a clearer view of legislative intent, since the rules in the *Code of Ethics* are, even under the above line of argument, only derivatively indicative of such intent? Or can it be argued that its so-called derivative status is irrelevant, on the ground that, since the medical profession is permitted to exercise this degree of control over itself, and since the Legislature so intended, the *Code of Ethics* has equal weight to that of the regulations?

The questions whether the rules of conduct of a self-governing profession constitute rules of law, and if so, whether they are co-equal with regulatory provisions (so that the ordinary rules of statutory interpretation should be applied in resolving conflicts), raise complex issues beyond the scope of this Report. As a practical matter, of course, the rules in the *Code of Ethics* impinge directly on the interpretation given to various types of "professional misconduct" by the committees of doctors dealing with complaints by members of the public. For example, the issue concerning what is "disgraceful, dishonourable or unprofessional conduct" is clearly influenced by the *Code of Ethics*. To this extent, then, and regardless of the precise legal effect of the Code, a doctor may bring to bear at a disciplinary hearing the fact that his conduct has been consistent with the ethical standards set forth in the *Code of Ethics*.

4. THE DONATION OF GAMETES

It hardly bears emphasizing that the selection of gamete donors is of critical importance, not only from the standpoint of their proven ability to have children, but also from the standpoint of their genetic and general medical status. Inadequate screening may set in motion a calamitous series of events for all persons involved. Yet, notwithstanding the centrality of the selection process, guidelines have not been developed for the medical profession in Ontario.[110]

The absence of such guidelines may reflect, in part, the lag in response to relatively novel medical techniques and, perhaps, the difficulty of establishing rules respecting the means of testing for suitability. Of course, to the extent that we are concerned with genetic and other medical testing, normal medical procedures presumably would, and do, apply. The negligent failure to conduct the proper tests on prospective donors could be the subject of a medical malpractice action.

---

[109] With respect to the right of the College of Physicians and Surgeons of Ontario to regulate the practice of medicine, establish standards of knowledge, skill, and qualification to practice, and establish standards of professional ethics, see *Health Disciplines Act*, *supra*, note 2, s. 46(2), reproduced *supra*, note 9. See, also, text accompanying note 10, *supra*.

[110] With respect to the different practices concerning the screening of donors, see *supra*, ch. 2, sec. 3(b)(i).

With respect to gamete donation, we shall deal first with the individual donor and then with sperm banks.

(a) THE INDIVIDUAL DONOR

There is legislation in Ontario that may have some impact on the donation of gametes for use in artificial conception programmes. Section 2 of the *Human Tissue Gift Act*[111] provides that "[a] transplant from one living human body to another living human body may be done in accordance with this Act, but not otherwise". Section 3(1) then states:

> 3.-(1) Any person who has attained the age of majority, is mentally competent to consent, and is able to make a free and informed decision may in writing signed by him consent to the removal forthwith from his body of the tissue specified in the consent and its implantation in the body of another living person.

The critical question is, of course, whether the Act applies to the donation of sperm or ova, or, put another way, whether sperm or ova come within the definition of "tissue" in the Act. Section 1(c) provides that " 'tissue' includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue that is replaceable by natural processes of repair".

There would appear to be little controversy that sperm comes within the closing flush of section 1(c) and, accordingly, is outside the purview of section 3(1). However, the same may not be said of ova. A woman's complement of ova is fixed and not replaceable; she loses one or more during menstruation from puberty to menopause. Accordingly, given the language of section 3(1), while sperm donation may be made by a minor, it would seem that a minor would be precluded from donating her ova, at least for the purpose of transplantation.

The proviso just noted warrants further brief comment. It may be arguable that section 3(1) of the *Human Tissue Gift Act*, by referring to the consent to the "removal forthwith" of tissue and its implantation in another person's body, is concerned essentially with tissue that is deliberately removed for the express purpose of transplantation; it may well not deal with the donation of tissue removed from the body for other purposes and subsequently transplanted.[112] Consequently, it may be that ova initially extracted for purposes other than transplantation — whether such extraction is the result of a gynecological operation — could be donated and implanted without violating the strictures of the Act.

---

[111] R.S.O. 1980, c. 210.

[112] While s. 3(1) may give some weight to this argument, s. 2 and the definition of "transplant" in s. 1(d) appear to be rather more rigid. In s. 1(d), " 'transplant' as a noun means the removal of tissue from a human body, whether living or dead, and its implantation in a living human body ...". The definition could comprehend the removal of tissue for any reason or purpose, and its subsequent transplantation.

Leaving aside the scope of the *Human Tissue Gift Act*, a donation of ova involves certain medical and, in some cases, surgical procedures, including a general anesthetic and a laparoscopy. Consequently, it is incumbent upon the attending physician to obtain the consent of the patient prior to the operation. There is now a rather large body of judicial opinion and commentary respecting the nature and scope of the duty of a doctor to disclose information to, and obtain the informed consent of, the patient.[113] While the issue of informed consent has been controversial, it is not unique to the field of medicine under consideration here. Moreover, legal doctrine respecting consents and the imparting of information have been supplemented by the Canadian Medical Association's *Code of Ethics*.[114] Under the Code, an "ethical physician" is enjoined to "recognize his responsibility to a donor of organs to be transplanted and [to] give to the donor or his relatives full disclosure of his intent and the purpose of the procedure; in the case of a living donor, he will also explain the risks of the procedure".[115]

A further issue that arises in respect of the donation of gametes concerns the payment of donors. Section 10 of the *Human Tissue Gift Act*[116] provides as follows:

> 10. No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy.

It should be noted that the prohibition in section 10 applies not simply to "tissue", which may exclude semen, but also to any body part. Accordingly, leaving aside the possible argument that semen for A.I.D. or I.V.F. is not used for "therapeutic purposes" — since the recipient woman is not seeking the semen to alleviate some illness or handicap on her part — it would seem that payment for sperm or ova as such may be invalid. But, in practice, semen donors are paid, presumably for their services and inconvenience rather than for the tissue or body part itself. Such payment, then, may well be characterized as being outside the four corners of the Act. However, as has been suggested, the section is somewhat ambiguous in its applicability to the artificial conception technologies. Moreover, the characterization of payment to donors as being for services and inconvenience, and not for a body part, may be thought to be rather disingenuous, having regard to what one may presume to be the true intent of the legislative prohibition.

We now turn to consider briefly the question whether a donor may withdraw his or her consent to the donation and use of the semen or ovum, or otherwise require that it be disposed of in a particular way. This matter is dependent, in part at least, on the legal characterization of the transaction.

---

[113] See, for example, *Hopp v. Lepp*, [1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67, and *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1.

[114] *Supra*, note 62.

[115] *Ibid.*, Responsibilities to the Patient, para. 21.

[116] *Supra*, note 111.

There is uncertainty concerning whether the supply of biological products is a sale of goods or a service. If the supply of semen or ova were regarded as a sale of goods, presumably the ordinary principles of sales law would apply with respect to the termination of the donor's property interest in the product upon completion of the transaction; a subsequent change of mind concerning the use of the sperm or ova would be to no legal avail. The matter might well be otherwise if the donation is only a service, thereby placing the donor in a position similar to that of a patient or research subject — who may withdraw consent at any time — and, therefore, leaving the donor with more options respecting the use of the gametes. In the United States, it should be noted, blood donation is regarded as a service transaction.

At present, it is usual in medical treatment and research for patients and subjects to be free to withdraw their consent at any time. However, donors are seldom patients or subjects. Moreover, as a practical matter, unlike patients and subjects undergoing medical treatment or participating in experimentation, donors ordinarily seek anonymity as a condition of donation.[117]

(b) SPERM BANKS

While there are, at present, no commercial — as opposed to university-based — sperm banks in Ontario, it is clear that there is a need for the law to deal expressly with the establishment and functioning of such bodies. Some of the critical issues may well be dealt with under the *Human Tissue Gift Act*, discussed in the immediately preceeding section. However, there are other important matters of concern, not related, for example, to questions of individual donation.

As we shall see later in this Report,[118] in 1981 a federal Advisory Committee on the Storage and Utilization of Human Sperm reported on, *inter alia*, the acquisition, preservation, and importation of sperm.[119] The general recommendation was that federal standards should be established to govern these matters. More specifically, the Committee believed that, "[u]ntil regulations establishing federal standards of quality are in effect for Canada, the importation of sperm from commercial human sperm banks should be prohibited; and no new human sperm bank should be allowed to operate outside the jurisdiction of a university or other publicly owned agency".[120]

On July 5, 1984, it was reported that the federal government was, in fact, planning to license sperm banks and establish criteria for donors.[121] The criteria would apparently deal with how sperm is obtained, prepared for storage, and screened for genetic and other diseases, although the scheme would not otherwise impose eligibility controls. In addition, detailed record keeping of donors would be required, with, for example, information concerning a donor's physical characteristics made available to recipients.

---

[117] However, there are cases where particular donors are selected by, and therefore are known to, the recipients, and where donors continue to have contact with the recipients.

[118] See *infra*, Appendix, sec. 2(a)(iii).

[119] Canada, Health and Welfare Canada, *Report of the Advisory Committee on the Storage and Utilization of Human Sperm* (1981), ch. II.

[120] *Ibid.*, at 16 and (xiv), recommendation 2.5. With respect to the use of frozen sperm from banks, see *ibid.*, at 29-30.

The licensing requirements would apply to both commercial sperm banks and existing, university-based sperm banks. All banks would be subject to federal government inspection. It was reported that the requirements would "get under way in six months to a year if sperm banks can be regulated under existing legislation".[122]

It should be noted that constitutional issues would be raised by any attempt by Ontario to prohibit, or even control, the importation of sperm from sperm banks outside Ontario. Federal law governs the "regulation of trade and commerce".[123] Moreover, the *Canadian Charter of Rights and Freedoms*[124] may also affect any attempted prohibition of transactions within Canada. Whether or not the reported federal initiative bears fruit, these and other matters should be canvassed before we are beset by what now appear to be only potential jurisdictional and other problems.

(c) CONCLUSION

Our review of existing law has convinced us that it has not kept pace with recent medical developments. We believe that it is of critical importance to deal expressly with such matters as the donation or use of gametes for artificial conception or other purposes, donations by minors, payments to gamete donors, the wrongful presentation of information by donors, the withdrawal of donations, gamete banks, and the importation of gametes from outside Ontario. In addition, we believe that there is uncertainty whether the supply of gametes is a sale of goods or a service, a matter that raises, for example, questions of products liability and warranties of quality and fitness. This matter, too, must be clarified.

---

[121] *The Globe and Mail*, Toronto (July 5, 1984), at 1.

[122] *Ibid.*

[123] *Constitution Act, 1867*, 30-31 Vic., c. 3 (U.K.), s. 91.2.

[124] *Supra*, note 22.

5. STATUS OF THE CHILD, PARENTAGE, AND BIRTH REGISTRATION

In this section, the Commission will examine the present law respecting the status and parentage of children artificially conceived, having regard to the normal law of parenthood and to the effect of the *Vital Statistics Act*[125] and *Children's Law Reform Act.*[126]

The status and parentage of an artificially conceived child bear directly on the critical factor of the child's "identity" and emotional security in his or her family. More specifically, status and parentage determine a number of rights and duties respecting the child, the parents, and others. For example, section 16 of the *Family Law Reform Act*[127] provides for the obligation of a "parent" to support "his or her child". Section 1(e) defines "parent" to mean, *inter alia*, "the father or mother of a child". While "father" is not defined, presumably it relates to biological fatherhood. What may be called social fatherhood is dealt with in that part of section 1(e) that provides that "parent" "includes a person who has demonstrated a settled intention to treat a child as a child of his ... family". Accordingly, a semen donor for A.I.D. or I.V.F. would be the parent who, in law, would owe a support obligation to the resulting child,[128] although another male person may, indeed, owe a similar duty under the Act as the social father.

The issue of the child's status and parentage is relevant in other circumstances as well. For example, the *Succession Law Reform Act*,[129] dealing, *inter alia*, with testate and intestate succession, defines "parent" to mean "the father or mother of a child".[130] Again, biological connection presumably determines the meaning given to these terms.

Of course, all those aware of a child's artificial conception and birth are entitled to make or deny provision for the child by will. But, for some reason, they may fail to make specific provision or may be ignorant of the circumstances of the conception. For example, a gift to the "children of X" — X being the husband of an A.I.D. recipient — would not, in law, comprehend the A.I.D. child. And the semen donor's bequest to his "children" would theoretically include that child.

The examples could be multiplied. However, the central point that bears emphasizing in this section is that the present law respecting status and parentage serves only accidentally to accommodate the intentions of participants in artificial conception programmes and the best interests of resulting children. As we shall see below, there are presumptions in the *Vital Statistics Act* and the *Children's Law Reform Act* that do assist in the regularizing of social relationships in certain circumstances, particularly where the social parents are married and cohabiting; but they are not applicable in all cases and, in any event, are rebuttable. They developed in a milieu largely ignorant of, or at least indifferent to, the new technological advances in the field of infertility and artificial conception.

---

[125] *Vital Statistics Act*, R.S.O. 1980, c. 524.

[126] *Children's Law Reform Act*, R.S.O. 1980, c. 68, as am. by S.O. 1982, c. 20 (adding to the Act Part III, dealing with custody, access, and guardianship).

[127] *Family Law Reform Act*, R.S.O. 1980, c. 152.

[128] In *C.M. v. C.C.*, 152 N.J. Super. 160, 377 A.2d 821 (N.J. Juv. Ct. 1977), the Court held, *inter alia*, that the semen donor, in this case known to the recipient, was liable for child support.

[129] *Succession Law Reform Act*, R.S.O. 1980, c. 488.

[130] *Ibid.*, s. 1(1)(d).

(a) THE LAW AND PRACTICE RESPECTING REGISTRATION OF BIRTHS UNDER THE *VITAL STATISTICS ACT*

In order to put the discussion of the birth registration system in its proper context, it may be appropriate to consider briefly the general purposes of such a system in Ontario. The system of birth registration established by the *Vital Statistics Act* is one of seven registration systems established under that Act. The Act provides for the creation of a uniform system of registration for births, marriages, deaths, still-births, adoptions, divorces, and changes of name in Ontario.[131] Once duly recorded, the information becomes, for all intents and purposes, facts that may be relied upon as evidence in any court in Ontario.[132]

In addition to functioning as a record of the circumstances of birth, the system of birth registration has a second purpose: along with the *Children's Law Reform Act*,[133] it is a means by which the parentage of children is established. As we shall see, the relationship of parent and child is presumptively established by the administrative act of registering the birth.

Having set out this background, we shall describe the present law and practice governing birth registration in Ontario. We turn first to the question of how birth information is transmitted to the registry and what information is transmitted and recorded.

Within two days of the birth of a child,[134] the attending medical practitioner must send a notice of birth to the registrar of the registration division within which the child was born.[135] The notice provides a minimum of information about the child and the circumstance of its birth and identifies the mother. The document, however, does not reveal any information respecting the paternity of the child.

---

[131] *Vital Statistics Act*, *supra*, note 125, s. 2(1). It should be emphasized that the Act is concerned only with events occurring in Ontario. The Act does not record events in the lives of residents of Ontario that do not occur within the Province. Moreover, the Act does not deal with events that occur to persons who move to or leave Ontario, where such events took place before their move to Ontario or after they left the Province, as the case may be.

[132] Section 42 provides, *inter alia*, that a birth certificate or a certified copy of a registration of birth "is admissible in any court in Ontario as *prima facie* evidence of the facts so certified".

[133] *Supra*, note 126. See discussion *infra*, this ch., sec. 5(b).

[134] Section 1(a) of the *Vital Statistics Act*, *supra*, note 125, defines "birth" to mean "the complete expulsion or extraction from its mother of a foetus that did at any time after being completely expelled or extracted from the mother breathe or show any other sign of life, whether or not the umbilical cord was cut or the placenta attached".

Within thirty days after the birth of the child, the mother, unless she is incapable,[136] must submit to the appropriate division registrar a statement, in a form prescribed by the regulations,[137] respecting the birth.[138] It is this document, known as the "Statement of Live Birth", that eventually will constitute the registration of birth.[139]

The information that is provided in the Statement of Live Birth depends, in the first instance, on the marital status of the mother. The Act requires that a mother state whether she is single, married, widowed, or divorced.[140] It provides further that the statement not state whether the parents of the child are married to each other.[141]

Regardless of the marital status of the woman, the prescribed statement will give information concerning the child and its date and place of birth and particulars respecting the mother, that is, her birth name, birthplace, date of birth, age, and social insurance number. Where the woman is married and was living with her husband when the child was conceived, the child must be given the surname of her husband, and the particulars of the husband must be given as those of the father of the child.[142] The legal presumption, then, in the case of a married, cohabiting couple, is that a child born during the currency of the marriage is the child of the couple. Again, however, it bears emphasizing that the presumption is rebuttable.

---

[135] *Vital Statistics Act*, *supra*, note 125, s. 5. See, also, R.R.O. 1980, Reg. 942, s. 1, Form 1.

[136] Section 1(k) of the *Vital Statistics Act*, *supra*, note 125, defines "incapable" to mean "unable through death, illness, absence from Ontario or otherwise". Where the mother of the child is incapable, the father must deliver the required statement, except where the child is born outside marriage. Where both parents are incapable, a person "standing in the place of the parents of the child" must submit the statement: see *Vital Statistics Act*, *ibid.*, s. 6(1)(b) and (c), and s. 6(2).

[137] R.R.O. 1980, Reg. 942, s. 2, Form 2.

[138] *Vital Statistics Act*, *supra*, note 125, s. 6(1).

[139] After receiving the Statement of Live Birth, the division registrar has 1 year from the day of birth of the child to register the birth by signing the statement, at which time the statement constitutes the registration of birth. Before signing, however, he must be satisfied as to the correctness and sufficiency of the statement: *Vital Statistics Act*, *supra*, note 125, s. 9(1).

[140] *Ibid.*, s. 6(3).

[141] *Ibid.*

[142] *Ibid.*, s. 6(4). It should be noted that, upon the joint request of the spouses, the birth of the child may be registered "showing the surname of the husband hyphenated or combined with the surname of the mother as the surname of the child": *ibid.*, s. 6(11)(a).

A married woman must not record her husband's particulars as being those of the father where she files a prescribed statutory declaration[143] stating that, when the child was conceived, she was living separate and apart from her husband, and that her husband is not the father of the child. In such a case, no particulars of the father are to be given in the statement. However, where the mother and a person who acknowledges himself to be the father of the child make a joint request in writing,[144] "the particulars of the person so acknowledging may be given as the particulars of the father, or the birth may be registered showing the surname of the person so acknowledging as the surname of the child, or both".[145]

Where an unmarried woman gives birth to a child, unless she and a person who, by statutory declaration,[146] acknowledges himself to be the father of the child jointly make a request to record the particulars of that person as those of the father and to show his surname as that of the child,[147] no particulars of the father shall be given in the statement.[148] Where, in the case of an unmarried mother, a statutory declaration is not made, the surname of the mother must be given to the child.

In the circumstances where, under the *Vital Statistics Act*, a person acknowledging paternity and the mother of the child have filed the requisite documentation to record the particulars of that person as those of the father, the *Children's Law Reform Act* provides for a rebuttable presumption that the male is, and shall be recognized in law to be, the father of the child, unless the contrary is proven on a balance of probabilities.[149]

From the foregoing description, it should be apparent that the integrity of the registration system, both as a record of birth[150] and a means of establishing or presuming paternity, depends on the diligence and honesty of individuals, who are required to submit accurate information in a timely fashion. A failure to file the requisite documentation or the deliberate transmission of erroneous information would undermine the system and impair its utility. To discourage such conduct, the *Vital Statistics Act* creates offences in the event of neglect or failure to submit required documentation or where a person wilfully has made or has caused to be made a false statement in a document required to be furnished under the Act.[151] However, as we shall see, accurate information may not in fact be conveyed to the registration authorities.

---

[143] R.R.O. 1980, Reg. 942, s. 3(2), Form 32.

[144] *Ibid.*, s. 3(3), Form 33.

[145] *Vital Statistics Act*, *supra*, note 125, s. 6(5).

[146] R.R.O. 1980, Reg. 942, s. 3(1), Form 31.

[147] *Vital Statistics Act*, *supra*, note 125, s. 6(8).

[148] *Ibid.*, s. 6(7).

[149] *Children's Law Reform Act*, *supra*, note 126, s. 8(1)5.

[150] In addition to serving as a record of the birth and parentage of a child, the registration serves as the basis for the issuance of a birth certificate. Information respecting the child and the circumstances of the birth must appear on the birth certificate: *Vital Statistics Act*, *supra*, note 125, s. 39(1). Section 55 of the regulations to the Act, R.R.O. 1980, Reg. 942, requires that the birth certificate be in Form 27. Formerly, s. 39 of the Act provided that the birth certificate shall contain particulars concerning "only" the child and the circumstances of its birth. This precluded any information respecting parentage. This was amended by the *Vital Statistics Amendment Act, 1983*, S.O. 1983, c. 34, s. 3, which deleted the word "only" from s. 39. Where there has been an adoption (see text accompanying notes 152-54, *infra*), the birth certificate is issued in accordance with the new registration, rather than in conformity with the original registration: *Vital Statistics Act*, *supra*, note 125, s. 24(4).

The birth registration may be altered by the subsequent adoption of a child, following a formal request and the submission of certain documentation by the adoptive parents.[152] The new registration records the birth and parentage of the adopted child as if it were born "in lawful wedlock"[153] as the natural child of the adoptive parents. Thus, the *Vital Statistics Act* does not mirror biological parentage, but reflects the new legal and social relationship that has been created by virtue of the adoption order.[154]

Given the use of the documentation maintained under the *Vital Statistics Act* in ostensibly establishing facts respecting birth and parentage, questions of confidentiality and access assume obvious importance. In view of our concern for these questions in the context of the use of artificial conception procedures, a consideration of the issue under Ontario legislation seems appropriate here. As is the case with other topics canvassed in this chapter, a brief review of the present law and practice will serve to put our subsequent discussion and recommendations in perspective.

The *Vital Statistics Act* can be characterized as having adopted a general approach of confidentiality, with some exceptions made for limited access by interested persons. For the public at large, the Act appears to contemplate negligible access. Section 49 provides that "[n]o division registrar, sub-registrar, funeral director or person employed in the service of Her Majesty shall communicate or allow to be communicated to any person not entitled thereto any information obtained under this Act, or allow any such person to inspect or have access to any records containing information obtained under this Act".[155] However, notwithstanding the exception for persons "entitled thereto", the Act in fact confers no absolute right of access in relation to birth documentation.[156]

---

[151] *Ibid.*, ss. 51-52.

[152] *Ibid.*, s. 24(2). The Registrar General will withdraw the original registration from the registration file and store it in a separate sealed file. On the original registration, there is a "notation" of the adoption and any consequential change of name.

[153] *Ibid.*, s. 24(2).

[154] See *Child Welfare Act*, *supra*, note 58, s. 86(1), and the new *Child and Family Services Act, 1984*, *supra*, note 58, s. 152(2).

[155] *Vital Statistics Act*, *supra*, note 125, s. 49. See, also, *ibid.*, s. 53, which creates an offence for contravening the confidentiality provision.

[156] See *ibid.*, ss. 40 and 41(1). By contrast, upon payment of the prescribed fee, any person may obtain a death certificate, and the parties to a marriage, their parents, or their

The release of birth documentation and disclosure of information has been left to the judgment of the Registrar General.

In order to have a search made for the fact that a birth has been registered, a person must satisfy the Registrar General as to his reason for requiring it.[157] In the event that the application is granted, the only information given to the person is whether the registration exists and, if it does, the registration number.[158]

Armed with the knowledge that there is a registration of birth, a person might wish to obtain a birth certificate or a certified copy of the registration. The Act provides that a birth certificate may be obtained by a person "who furnishes substantially accurate particulars, and satisfies the Registrar General as to his reason for requiring it".[159] Apparently, this language has been interpreted by the Registrar General to confine access to the persons named in the registration — the child and his parents. Other relatives and strangers, as a matter of practice, are not given birth certificates.

Access to a certified copy of the registration, which contains information respecting the parentage of the child, would appear to be even more restricted. Under the Act, a certified copy cannot be issued "except to a person authorized by the Registrar General or the order of a court".[160] In practice, as with the birth certificate, access is restricted to persons who are named in the registration.

The question of access to the documentation acknowledging paternity that may be filed by an unmarried woman or by a married woman living separate and apart from her husband at the time of conception is addressed by the *Children's Law Reform Act*. It provides that "any person who has an interest, furnishes substantially accurate particulars and satisfies the Registrar General as to his reason for requiring it", may inspect and obtain a certified copy of the documents.[161] Presumably, the necessary interest would be found if, for example, the person were seeking to establish paternity by relying on the statutory presumption under section 8 of that Act.

We now turn to consider the interaction between the *Vital Statistics Act* and the new reproductive technologies. Can the new artificial conception technologies be adequately accommodated within the existing system of birth registration, given that the present law and practice were developed in a world in which natural reproduction was automatically assumed and artificial reproductive technology either did not exist or was rarely used?

---

children may obtain a marriage certificate: see *ibid.*, s. 40(2) and (3)(a)-(c). No discretion to refuse a certificate appears to reside in the Registrar General.

[157] *Ibid.*, s. 44(1)(c).

[158] *Ibid.*, s. 44(3).

[159] *Ibid.*, s. 40(1).

[160] *Ibid.*, s. 41(1).

[161] *Children's Law Reform Act*, *supra*, note 126, s. 13.

The various reproductive technologies in current and foreseeable use may allow children to be produced by numerous combinations of participants. Depending on how the term "parent" is to be defined, several individuals involved in the creation of a single infant may justifiably claim that status by reason of some form of connection to the child. Whether a particular category of person should be allowed to claim to be a parent is a policy issue, the resolution of which will affect an evaluation of the adequacy of the existing system of birth registration. If, for example, we take the view that biology should be determinative of parentage, the gamete donor or donors or the gestating woman in the surrogate motherhood situation would be regarded as parents for purposes of birth registration.

How the system of birth registration should respond to the advent of these technologies, and the difficult questions that they pose, may appear less intractable if one recalls the ostensible purpose of registration under the *Vital Statistics Act*. Earlier, it was stated that birth registration records the circumstances of a birth and establishes the parentage of the child. However, bearing in mind the previous discussion concerning birth registration, it may be said that the Act is not really intended to — and certainly does not always — establish a true biological record of parentage. Rather, registration by and large creates a social record of parentage, which ordinarily conforms to the reasonable expectations of individuals and of society as to the origins of children. In many cases — perhaps the overwhelming majority — this expectation is consistent with the biological truth, but this is not invariably the case.

The fact that the biological truth does not necessarily govern is strikingly evident in the treatment of children born during the subsistence of a marriage. Except where she has filed a statutory declaration stating that, at the time of conception, she was living apart from her husband and that her husband is not the father of her child, a married woman must give the particulars of her husband as those of the father of the child in the Statement of Live Birth. Even where it can be proved that the child in fact has been conceived in the course of an adulterous relationship, during which the spouses were not living separate and apart from each other, the particulars of the husband must be recorded as those of the father of the child.[162] In some cases, then, biological accuracy gives way to what may be regarded as the social reality that the child will be raised by the husband as his own. However, in other cases — where, for example, a child conceived in the course of an extra-marital relationship is not, in fact, raised by the husband as his own — neither biological nor social reality is reflected in the register.

There are other illustrations of how the purity of the birth register, as a repository of biological truth, has been eroded. For example, where a widow gives birth to a child conceived by her deceased husband, she is technically unable to use section 6(4) of the Act to give the child her husband's surname and her husband's particulars as those of the father, for the woman is not "married" at the time of birth. However, we understand that, in practice, widows may, and do, utilize section 6(4). Indeed, since there is nothing in the applicable form to indicate the husband's date of death, a widow could conceivably use the section even where the husband could not have been the father; it appears that no inquiry is, in fact, made as to the accuracy of the information provided.[163]

---

[162] Of course, in a judicial proceeding, a birth certificate and a certified copy of a registration of birth is only *prima facie* evidence of the facts so certified: *Vital Statistics Act*, *supra*, note 125, s. 42. Moreover, the presumption that the husband is the father is rebuttable under the *Children's Law Reform Act*, *supra*, note 126: see ss. 4 and 8(1).

The frequent subservience of biological fact to social reality in the *Vital Statistics Act* is evidenced further, and most obviously, in the response to adoption. As we have seen, where proper application has been made, the original registration of birth is replaced by a new registration, which records the fiction that the adopted child has been born to the adoptive parents "in lawful wedlock". While the original registration is to bear a notation of the adoption and of any consequential change of name, it is to be kept in a separate, sealed file, which is generally unavailable.

With respect to the application of the law governing birth registration to the artificial conception technologies in question, we find that, in the case of artificial insemination by donor and *in vitro* fertilization with donor sperm or ova, where the couple is married, the *Vital Statistics Act* ordinarily is in harmony with the wishes of the social parents and, presumably, the needs of the child. In the case of artificial insemination by donor, the particulars of the recipient's husband will appear on the registration as being those of the father of the child. Where the woman is in an unmarried relationship, however, the *Vital Statistics Act* cannot be used to "regularize" the birth: section 6(7) of the Act would prevent her male partner from being recorded as the father of the child, unless he were falsely to acknowledge himself as the father pursuant to the provisions of section 6(8).

In the case of *in vitro* fertilization, where the fertilized ovum is implanted in a married woman, the operation of the *Vital Statistics Act* would result in her and her husband being registered as the mother and father of the child, irrespective of whether one or both of the gametes were donated. In other words, even where the child has no genetic relationship to the adults who are going to raise it as their own, they will be registered as its parents under the *Vital Statistics Act*. Again, however, the expectations of unmarried couples cannot be realized under the Act.

Notwithstanding that the *Vital Statistics Act* was not drafted with the artificial conception technologies in mind, the result that it produces for married couples in the situations discussed above is, then, ordinarily viewed by them to be the appropriate one: not only does it give effect to the intentions and expectations of the adult participants in these technologies, but also it is perceived to be in the best interests of the child. Moreover, from one perspective, it is not inconsistent with the Act's function as a record of social parentage, rather than a record of pure genetic or biological origin.

---

[163] It should also be noted that there is a presumption under the *Children's Law Reform Act*, *supra*, note 126, that a male person is the father of a child where, for example, the "person was married to the mother of the child by a marriage that was terminated by death ... within 300 days before the birth of the child": *ibid*., s. 8(1)2. The widow could apply for a paternity declaration making use of this presumption: *ibid*., s. 4. With respect to a subsequent amendment of the birth register, see *ibid*., s. 16.

When we turn to consider the artificial conception technologies that involve a woman who gives birth to a child and subsequently transfers the custody of the infant to another woman who is to raise it as her child — that is, surrogate motherhood — the *Vital Statistics Act* simply does not accommodate the intentions of the parties. While there is no definition of "mother" in the statute, it seems clear from the definition of "birth"[164] that only the woman who gives birth to a child is its mother. As a consequence, the surrogate mother must be registered as the mother, notwithstanding that she wishes to have nothing further to do with the child. Where the woman giving birth is married, the particulars of her husband would be recorded as those of the father, except where she files a statutory declaration stating that, at the time of conception, she was living separate and apart from her husband, and that her husband is not the father of her child.[165] This result would ensue irrespective of the source of gametes. Thus, it would apply, for example, whether the surrogate mother bears a child created with her own ovum, the ovum of the woman who is to raise the child as her own, or, indeed, the ovum of any other woman.

In these cases, then, the operation of the *Vital Statistics Act* will frustrate the intentions of the parties and oblige them to follow adoption procedures to establish, in law, the parental relationships that they all wish.[166] Of course, where the man who is to be the social father of the child is also the sperm donor, he and the surrogate mother, if unmarried, can file a statutory declaration requesting that his particulars be recorded as those of the father of the child.[167] As a consequence, should he be registered as the father, only his wife or common law partner would need to adopt the child in order to regularize the child's relationship to her.[168]

---

[164] See definition of "birth" quoted *supra*, note 134.

[165] *Vital Statistics Act*, *supra*, note 125, s. 6(5).

[166] We shall return to the adoption procedures applicable in surrogate motherhood in sec. 8(b) of this chapter (see esp. *infra*, note 268). Where the child is given up by the surrogate mother to the biological father and his wife, the wife must use the step-parent adoption procedures set forth in Part III of the *Child Welfare Act*, *supra*, note 58. The procedure governing step-parent adoption has been considerably simplified to ease adoptions. Where, however, the biological father is not married to the woman with whom he is living, the court may not make an adoption order in favour of the unmarried woman unless it "is satisfied that there are special circumstances that justify the making of the order" (*Child Welfare Act*, *ibid*., s. 74(1)(b)). And, of course, in such a case, the normal, rigorous investigatory rules — not the step-parent adoption rules — apply.

Under the new *Child and Family Services Act, 1984*, *supra*, note 58, however, the step-parent adoption procedure is available to the unmarried woman cohabiting with the child's natural father: see *ibid*., s. 140(2)(c), and the definition of "spouse" under s. 130(1)(d). The term " 'spouse' has the same meaning as in Parts I and II of the *Human Rights Code, 1981*," *supra*, note 20. Section 9(j) of the Code defines "spouse" to mean "the person to whom a person of the opposite sex is married or with whom the person is living in a conjugal relationship outside marriage".

[167] *Vital Statistics Act*, *supra*, note 125, s. 6(8).

From the foregoing discussion, the question clearly arises concerning whether the *Vital Statistics Act* should be amended to accommodate the intentions of the parties where such intentions are now frustrated. However, the resolution of this issue would appear to depend on how one resolves the more fundamental questions regarding the status of the child, particularly in the context of surrogate motherhood.

(b) THE ESTABLISHMENT OF PARENTAGE OUTSIDE THE *VITAL STATISTICS ACT*

In addition to the *prima facie* establishment of parentage under the *Vital Statistics Act*, parentage may be established by a declaration of maternity or paternity by a court under Part II of the *Children's Law Reform Act*.[169] Without describing in detail the full scope of Part II, it seems appropriate to make a few comments germane to the present discussion.

Section 4(1) of the Act deals with applications by an interested party for a declaration of paternity or maternity. Section 4(2) then provides as follows:

> 4.-(2) Where the court finds that a presumption of paternity exists under section 8 and unless it is established, on the balance of probabilities, that the presumed father is not the father of the child, the court shall make a declaratory order confirming that the paternity is recognized in law.

Section 8(1) provides that, unless the contrary is proven on a balance of probabilities, there is a presumption of paternity in respect of a male person in six cases, including where, for example:

> 1. The person is married to the mother of the child at the time of the birth of the child.
>
> . . .
>
> 5. The person and the mother of the child have filed a statutory declaration under subsection 6(8) of the *Vital Statistics Act* or a request under subsection 6(5) of that Act ....

Section 5 of the *Children's Law Reform Act* deals, *inter alia*, with applications for a declaration of paternity where none of the section 8 presumptions is applicable. In such a case, any person may apply for a declaration that a person is his or her father, and any male person may apply for a declaration that a person is his child. However, no application may be made "unless both the persons whose relationship is sought to be established are living".[170]

---

[168] See discussion *infra*, this ch., sec. 8(b). With respect to adoption by an unmarried person, see *supra*, note 166.

[169] *Supra*, note 126.

[170] *Children's Law Reform Act*, *supra*, note 126, s. 5(2).

The *Children's Law Reform Act* provides that declaratory orders made under the Act "shall be recognized for all purposes".[171] Moreover, under section 14, such an order is forwarded to the Registrar General and a certified copy of it is obtainable "[u]pon application" by "any person". A "certificate certifying a copy of a document to be a true copy, obtained under section ... 14 ... is ... receivable in evidence as *prima facie* proof of the filing and contents of the document for all purposes in any action or proceeding".[172] Finally, section 16 of the Act provides that "[n]othing in this Act shall be construed to require the Registrar General to amend a registration showing parentage other than in recognition of an order made under section 4, 5 or 6".

While, under the *Children's Law Reform Act*, the Supreme Court of Ontario and the Unified Family Court have jurisdiction to make a declaration in the nature of a judgment *in rem*, recognizable for all purposes,[173] an application under the Act does not provide the only occasion for a court to determine parentage: a court may make such a determination in the course of any dispute where the issue is material to the litigation. However, such a declaration is relevant only for the purposes of the proceedings in question. For example, it has been held that a court has jurisdiction to determine parentage for the purpose of a support order under the *Family Law Reform Act*[174] and for the purpose of dependants' relief under the *Succession Law Reform Act*.[175]

The relationship between the new artificial conception technologies and the means of establishing parentage described in this section of the Report is, in part, a refinement of the relationship between these technologies and the *Vital Statistics Act*. As we have seen, that Act provides for the registration of the particulars of certain male persons — for example, the husband of a woman with whom he cohabits — as the father of a particular child. The rebuttable presumptions that arise are reflected in section 8(1)1 and 5 of the *Children's Law Reform Act*. And where a "person having an interest" applies under section 4 for a declaration of paternity founded upon these presumptions, and they are not rebutted on the balance of probabilities, a declaratory order *in rem* may be made.

However, it bears mentioning that, aside from the fact that the presumptions under section 8(1)1 and 5 are rebuttable, the use of a presumption to obtain a declaratory order of paternity would require the applicant to lie concerning parentage where, for example, a married man seeks such an order in respect of an A.I.D. child born to his wife. Accordingly, regularization of the status of children born as a result of I.V.F. or artificial insemination using donor semen is not possible unless the social parent is prepared to found his application for a declaratory order on a lie.

---

[171] *Ibid.*, ss. 4(4) and 5(3).

[172] *Ibid.*, s. 15.

[173] *Ibid.*, s. 3. See *Sayer v. Rollin* (1980), 16 R.F.L. (2d) 289 (Ont. C.A.), esp. at 292, and *Re Ruby* (1983), 43 O.R. (2d) 277 (Surr. Ct.), esp. at 280.

[174] *Supra*, note 127. See *Sayer v. Rollin*, *supra*, note 173.

[175] *Supra*, note 129. See *Re Ruby*, *supra*, note 173, citing *Sayer v. Rollin*, *supra*, note 173.

It will be recalled that, without a formal statutory declaration by an unmarried woman and a person who acknowledges his paternity, as set forth in section 6(8) of the *Vital Statistics Act*, no particulars of the father of a child of an unmarried woman are to be given for the purposes of that Act. But, under section 8(1)4 of the *Children's Law Reform Act*, there is a presumption that a male person is the father of a child where he "was cohabiting with the mother of the child in a relationship of some permanence at the time of the birth of the child or the child is born within 300 days after they ceased to cohabit". Again, however, it must be stressed that this presumption is rebuttable.

In other words, under the circumstances described in the preceding paragraphs, present Ontario law generally can accommodate the intentions of the parties and recognize social realities.[176] Such is not the case, however, where surrogate motherhood is involved. Even though, where artificial insemination is used and the semen donor is also to be the social father, the father may apply under the *Children's Law Reform Act* for a declaration that the surrogate mother's child is also his child,[177] the Act does not go further to accommodate the intentions of all the parties. For example, the father's spouse will remain a legal stranger to the child and cannot be registered as the child's mother, unless, of course, she is permitted to adopt him or her.

(c) BIRTH REGISTRATION, INHERITANCE RIGHTS, AND THE POSTHUMOUSLY CONCEIVED A.I. OR I.V.F. CHILD

While not a matter of substantial concern today, and not likely to increase dramatically in importance in the foreseeable future, the status of children posthumously conceived by means of artificial conception — through the use of cryopreserved sperm — does raise some practical and policy questions. These questions relate primarily to the status and parentage of such children, as well as to the manner in which their births are registered. But also of importance are related matters pertaining to rights of inheritance — rights that depend on status and parentage.

With respect to the parentage of the child, reference should be made to the rebuttable presumption in section 8(1)2 of the *Children's Law Reform Act*.[178] This section provides, *inter alia*, that a male person is presumed to be the father of a child where he "was married to the mother of the child by a marriage that was terminated by death ... within 300 days before the birth of the child ...".

---

[176] With respect to this issue, see Uniform Law Conference of Canada, *Proceedings of the Sixty-Fourth Annual Meeting* (1982), Appendix F, at 86, which reproduces the Uniform Child Status Act. Section 11 of the Act deals with the legal status of the parties involved in A.I. and I.V.F. See discussion *infra*, Appendix, sec. 3(b)(ii).

[177] But see the American case of *Syrkowski v. Appleyard*, unreported (November 25, 1981, Wayne Co. Cir. Ct., Mich.), aff'd 122 Mich. App. 506, 333 N.W. 2d 90 (1983), where the parties to a surrogate mother arrangement unsuccessfully attempted to use the Michigan *Paternity Act* to establish the paternal rights of the semen donor.

See, also, *In re Baby Girl*, unreported (March 18, 1983, Jefferson Cir. Ct., Ken.), and *In the Petition of R.K.S. for Adoption*, 10 F.L.R. 1381 (Sup. Ct., Fam. Div., D.C. 1984).

[178] *Supra*, note 126.

As we have seen, provision is made in the Act for obtaining a declaration that the male person in question is recognized in law to be the father of a child.[179] Declaratory orders may, then, form the basis of a formal amendment to the birth register.[180]

Where, however, the birth of the artificially conceived child takes place beyond the 300 day period after the mother's husband's death, there is no statutory presumption that the husband is the father. Moreover, while, under section 5(1), an application for a declaration of paternity may be made "[w]here there is no person recognized in law under section 8 to be the father of a child", such an application "shall not be made ... unless both the persons whose relationship is sought to be established are living".[181]

However, it would appear that, as a matter of practice, the presumption under section 8(1)2, the procedure to obtain a declaration of paternity and to have the birth register amended accordingly, and the impediment to this procedure where the child's birth occurred more than 300 days after the husband's death do not necessarily affect the recording of a child's surname and the particulars of his father where the child was conceived and born posthumously. It will be recalled that, where a widow completes a Statement of Live Birth, she may, for example, record her deceased husband's surname and particulars as those belonging to the child's father. It appears that, as a matter of practice, the Statement is accepted under the *Vital Statistics Act* without any inquiry being made concerning, for example, the husband's date of death.

Where the child's father is the deceased husband of the child's mother, the fact that the latter utilizes, or is in practice permitted to utilize, section 6(4) of the *Vital Statistics Act*, even though she is not "married" at the time of the birth, may not shock one's conscience. However, such subterfuge does bear witness to the need to reform the law.

(d) CONCLUSION

In this portion of the chapter, we have examined the law concerning the status and parentage of artificially conceived children, having regard to the provisions of the *Vital Statistics Act* and the *Children's Law Reform Act*. These issues bear critically on the issue of what we may call a child's "identity" and on such important related matters as support obligations and inheritance rights.

The main thrust of our description of the present law — indeed, both here and in other sections — is to illustrate the proposition that the law frequently ignores the implications of artificial conception or only accidentally serves to accommodate or further the reasonable expectations of the parties and the well-being of the children. Admittedly, the provisions in the *Vital Statistics Act* and the *Children's Law Reform Act* do go some considerable distance toward "regularizing" existing social relationships between social parents and children. A married couple who has an artificially conceived child using donor gametes can rely on the presumption that the husband is the father: the husband's surname is shown as the child's surname, and the husband's particulars are given as those of the father of the child.[182] Where the gamete donor is anonymous and has no practical way of discovering the children conceived with his or her gametes, the likelihood of anyone disturbing this state of affairs is not substantial.

---

[179] *Ibid.*, s. 4.

[180] *Ibid.*, s. 16.

[181] *Ibid.*, s. 5(2).

But, as we have emphasized throughout the discussion, the presumptions under the *Children's Law Reform Act* are rebuttable. A male person seeking to use the married person's presumption in order to obtain a declaratory order of paternity could be met with evidence that the child was artificially conceived with someone else's semen. Moreover, in his quest to regularize his relationship with the child, his very application for such an order would have to be founded on a lie, since he is not the natural father.

The donor, too, could discover his progeny and seek a declaratory order of paternity under the *Children's Law Reform Act* as a basis for obtaining custody. While the social parents may deny the fact of artificial conception, the donor may well be able to locate, and subpoena, medical records that indicate the contrary and establish his own paternity; indeed, the donor may have his paternity confirmed at this juncture by medical testing.

The spectre of legal assaults on the relationship between the social parents and the child is, we believe, unwholesome. The possibility that lies may be used in order to regularize such a relationship is also unacceptable. It is not simply that the two Acts to which we have been referring are out of touch with social realities and manifest significant gaps and, indeed, aberrations,[183] or that the intentions of the parties are often frustrated or only fortuitously realized. More importantly, we are of the view that the present law relating to status, paternity, and birth registration generally does not serve the interests of artificially conceived children as well as it should. Only direct legislative intervention can cure defects inherent in a legal regime designed in and for a different era.

---

[182] *Vital Statistics Act*, *supra*, note 125, s. 6(4).

[183] In this connection, it should be noted that amendments to the present *Vital Statistics Act* are contemplated. During the 1983 estimates, the Minister of Consumer and Commercial Relations, the Hon. Dr. Robert G. Elgie, made the following statement (Leg. Assembly of Ont., *Hansard*, Official Report of Debates, Standing Comm. on Admin. of Justice (No. J-16, November 30, 1983), at J-367):

> The last major revision to the Vital Statistics Act was in 1948 when commonly accepted social conventions were significantly different from those of today. For example, the current legislation makes no allowances for a mother who may not want to use the natural father's surname when naming her child. At best, under the current laws, a child's last name can include a mother's surname only if her name is used in combination with the surname of the natural father or her husband.
>
> A provincial government legislator in the 1940s could hardly be blamed for failing to anticipate the day when a newborn child might not be named after anyone but the father, even if that father were dead or long gone. Times have changed and certain of our laws must change to recognize that fact.

6. MEDICAL RECORDS: COMPOSITION, RETENTION, ACCESS, AND CONFIDENTIALITY

In the 1980 Ontario *Report of the Commission of Inquiry into the Confidentiality of Health Information* (the Krever Report),[184] it was said that seventy-seven pieces of legislation, including regulations, dealt with the reporting, collection, storage, use, dissemination, confidentiality, retention, or disposal of health information. To assimilate this material is clearly an extremely difficult task, particularly since there appears to be no coherent pattern to the legislation in respect of medical records. In this latter connection, the Krever Report stated:[185]

> The legislative treatment of health information is extremely inconsistent. When gathered together, the relevant sections may appear to comprise a formidable body of law. However, in this case, the whole is not greater than the sum of its parts. The whole is merely a collection of piecemeal provisions. No general code is established for the handling of health information. No comprehensive policy is reflected in the present legislation.

Moreover, to add to the confusion, it was noted that "[m]ost dealings with health information are not covered in any way by legislation".[186]

It is not intended to canvass all the statutes and regulations reviewed in the Krever Report. Indeed, most of them are not germane to our topic, and a detailed analysis of those that are relevant is not essential for our purposes. Suffice it to describe the main features of the legal regime governing medical records in order to provide a background to our subsequent proposals for reform.

Given the fact that, in the main, artificial conception is confined to public hospitals or individual medical practitioners, reference will be made in this section to the law governing the practice in these two contexts. More specifically, we shall canvass such areas as ownership, custody, safekeeping, disposal, patient consent to disclosure, third party disclosure, and confidentiality of records generally.

The topic of medical records in the context of artificial conception is important for a number of reasons. For example, given the general novelty of the practice and its relatively recent origins, information contained in medical records could serve an extremely important statistical and research function. Aside from this purpose, the linkage of semen donations and donors to outcomes of artificial insemination would indicate whether individual donors can achieve conceptions. More importantly, some kind of linkage between donors and recipients would be necessary where critical medical and genetic information is required. A child may be born with some disease or genetic impairment, the treatment of which may require access to health information and family medical history from the gamete donor. Moreover, linkage between donor and recipient may be important in order to alert the donor to the fact that he or she is a carrier of a genetic disease.[187]

---

[184] Ontario, *Report of the Commission of Inquiry into the Confidentiality of Health Information* (1980) (hereinafter referred to as "Krever Report").

[185] *Ibid.*, Vol. I, at 51.

[186] *Ibid.*, at 52.

Finally, access to certain information may be sought by the artificially conceived child. Having regard to the experience with adopted children, it is reasonable to expect that some artificially conceived children may attempt to uncover their origins and the name and residence of the gamete donor involved in their conception.[188]

We begin with a consideration of the position of the individual physician, outside the hospital context. The requirement to keep records on patients is expressed in the regulations promulgated under the *Health Disciplines Act*.[189] The basic rule provides as follows:[190]

> 29.-(1) A member [of the College of Physicians and Surgeons of Ontario] shall,
>
> (a) keep a legibly written or typewritten record in respect of each patient of the member setting out,

---

[187] See, by analogy, the new *Child and Family Services Act, 1984*, *supra*, note 58, s. 157(2)(d), which provides, *inter alia*, that the general prohibition respecting the disclosure of adoption information does not apply to "the disclosure of information of a prescribed class to a person whose access to the information, in a Director's opinion, is necessary to protect any person's health ...".

See, also, s. 166(1)(f) of the Act. This section provides that the normal rule against the disclosure of certain records of a child under 16 without, for example, the consent of a parent does not apply to disclosure

> (f) to a person who is providing medical treatment to the person whose record is concerned, if the service provider [the person who, for example, provides a child welfare or other service to the child and who has control of the record] believes on reasonable grounds that,
>
> (i) failure to disclose the record is likely to cause the person whose record is concerned physical or emotional harm, and
>
> (ii) the need for disclosure is urgent; ...

With respect to linkage, see, generally, *supra*, ch. 2, sec. 3(b)(i).

[188] Since adoption raises sensitive, personal issues for the child and the natural and adoptive parents, it is understandable that most persons in this situation prefer the matter to be kept private. This legitimate wish is, to a great extent, reflected in the current legislation. Yet, there has been some move toward permitting access by adopted children and their natural parents to the facts surrounding the child's birth and adoption. In Ontario, this trend is made manifest by the existence of a voluntary disclosure register: see *Child Welfare Act*, *supra*, note 58, s. 81, and *Child and Family Services Act, 1984*, *supra*, note 58, s. 158.

[189] *Supra*, note 2.

[190] R.R.O. 1980, Reg. 448, s. 29(1).

. . .

> (v) investigations ordered by the member and the results of the investigations,
>
> (vi) each diagnosis made by the member respecting the patient, and
>
> (vii) each treatment prescribed by the member for the patient; ...

The "failure to maintain the records that are required to be kept respecting a member's patients" is professional misconduct on the part of the doctor.[191] With respect to the retention of medical records, the regulations provide that each member of the College "shall retain each record for a period of six years after the date of the last entry in the record or until the member ceases to engage in the practice of medicine, whichever first occurs".[192]

Critical to the matter of medical records is confidentiality. In this connection, the Krever Report noted that there was "[e]thical and legal support for the concept of confidentiality" in the ethical canons and legislation governing the medical profession.[193] Under the regulations, professional misconduct includes "giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law".[194]

In addition to the above-noted injunction respecting disclosure of health information, the *Code of Ethics* of the Canadian Medical Association provides that an ethical physician "will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him to do so".[195] With respect to the patient's control over medical information concerning him or her, it should be noted that, where a patient requests the doctor to make available to his colleagues a "report of his findings and treatment" of the patient, the doctor is under a duty to do so.[196]

Where treatment is provided in a public hospital, additional legislation governs the retention, ownership, confidentiality, and destruction of medical records. Regulations under the *Public Hospitals Act*[197] provide for the compilation of a medical record for each public hospital patient and list the required contents in some detail. For example, a record must include orders for treatment, progress notes, and reports of laboratory examinations, medical, surgical and obstetrical treatment, and physical examinations.[198]

---

[191] *Ibid.*, s. 27.3. See, also, *supra*, this ch., sec. 3(d), respecting the sanction for professional misconduct.

[192] R.R.O. 1980, Reg. 448, s. 29(2).

[193] *Supra*, note 184, Vol. II, at 379.

[194] R.R.O. 1980, Reg. 448, s. 27.22. See *Halls v. Mitchell*, [1928] S.C.R. 125, [1928] 2 D.L.R. 97.

[195] *Code of Ethics*, *supra*, note 62, Responsibilities to the Patient, para. 6.

[196] *Ibid.*, Responsibilities to the Profession, para. 18.

[197] *Supra*, note 27.

The physician "who makes any part of a record prescribed by" the regulations must "deliver the part to the administrator" of the hospital.[199] Section 11 of the *Public Hospitals Act* then provides that "[t]he medical record compiled in a hospital for a patient or an out-patient is the property of the hospital and shall be kept in the custody of the administrator".[200]

The regulations under the *Public Hospitals Act* provide, in some detail, for the retention and disposal of medical records and related records that, strictly speaking, do not form part of the medical record. Each hospital board may establish its own practice respecting, for example, the photographing of medical records "in order to keep a permanent record thereof".[201] Photographs of such records must be kept for fifty years and "may be destroyed thereafter by the administrator".[202] Different retention periods apply to photographed and non-photographed records, records of patients or out-patients under and over eighteen years of age, and special types of record, such as X-ray films, nurses' notes, and so on. Again, after the particular period has elapsed, the administrator may destroy the records and then shall make a statutory declaration to that effect.[203]

With respect to the critical issue of access and confidentiality, the Krever Report stated that "[n]o consistent treatment or coherent policy ... is reflected in Ontario legislation".[204] The general provision respecting access to and confidentiality of medical records in a public hospital applies to both patients and third parties and provides that, subject to access by inspectors, coroners or persons authorized by coroners, the Registrar of the College of Physicians and Surgeons of Ontario or persons appointed by the College, and persons with a judicial process, "a board shall not permit any person to remove, inspect or receive information from a medical record".[205]

---

[198] R.R.O. 1980, Reg. 865, s. 38(1). There are, as well, other provisions in the regulations that deal with medical records in different contexts — for example, where there has been "a pathological or other laboratory examination of a patient or an out-patient" or "any tissue, fluid or other material [has been] removed from a patient or an out-patient" (*ibid.*, s. 35(1)). However, subject to some exceptions, "nurses' notes", for example, "need not be ... retained as part of the medical record ..." (*ibid.*, s. 46(1)), but must still be retained as prescribed by s. 46(3).

[199] *Ibid.*, s. 39(1).

[200] See, also, *ibid.*, s. 39(2), which provides that "[t]he administrator is responsible for the safekeeping of all records relating to a patient".

[201] *Ibid.*, s. 42(1). See, also, *ibid.*, s. 45(1).

[202] *Ibid.*, s. 42(3).

[203] *Ibid.*, s. 43.

[204] Krever Report, *supra*, note 184, Vol. 1, at 55.

[205] R.R.O. 1980, Reg. 865, s. 49(1). See *Health Disciplines Act*, *supra*, note 2, s. 65, respecting the preservation of secrecy by "[e]very person employed in the administration of this Part [Part III], including any person making an inquiry or investigation under section 64, and any member of the Council [of the College of Physicians and Surgeons of

With specific reference to the rights of patients, it may be said that their ability to obtain information contained in their own medical records is extremely limited; indeed, they have no direct right of access at all. It appears that the relevant legislation contemplates only indirect access to medical records in a public hospital by a patient. The regulations provide, for example, that a hospital board "may permit" the "attending physician" or "a person who presents a written request signed by ... the patient" to "inspect and receive information from a medical record and to be given copies therefrom".[206] Access is, therefore, at the sufferance of the board (with, it appears, no redress if access is refused[207]), as well as at the sufferance of the third party to whom the information is given.[208]

While, in this Report, we are not concerned with the topic of medical records generally, we do wish to stress particularly the question of confidentiality and anonymity in the context of records that contain information respecting the provision of artificial conception services. We understand that the practice of most doctors is to keep records that link donors to recipients, while at the same

---

Ontario] or a Committee ..." (s. 65(1)). No such person shall disclose the relevant information except, *inter alia*, "with the consent of the person to whom the information relates" (*ibid.*, s. 65(1)(d)). It appears, however, that the latter provision does not give a third party the right to such information; nor can the subject of the information compel disclosure. Holders of this information are simply given the authority to disclose it with, for example, the subject's consent.

In *Re Stumbillich and Health Disciplines Board* (1983), 44 O.R. (2d) 196, 3 D.L.R. (4th) 417 (Div. Ct.) (subsequent references are to 44 O.R. (2d)), it was held, *inter alia*, that s. 65 is not "a bar to disclosing information to a complainant when such information is of a kind reasonably necessary to permit the complainant to prepare or present his or her claim" (*ibid.*, at 202). However, the Court also stated (*ibid.*, at 204-05):

> [F]or the reasons discussed in *Re Egglestone and Mousseau and Advisory Review Board* (1983), 42 O.R. (2d) 268, 150 D.L.R. (3d) 86, 6 C.C.C. (3d) 1, there may well be occasions when, in the discretion of the board, particular material may be withheld in the interests of a patient or some person vitally concerned. Such discretion must, however, be exercised with great care and production must be the rule.

The Divisional Court decision was upheld by the Court of Appeal: (1984), 47 O.R. (2d) 545 (C.A.). The Court of Appeal stated that the Health Disciplines Board retained some discretion to withhold records, but that it must be exercised with "great care".

[206] R.R.O. 1980, Reg. 865, s. 49(6)(a) and (c)(i). See Krever Report, *supra*, note 184, Vol. I, at 64-65, where it was noted that the patient's access to his or her medical record is not contemplated by this provision.

[207] See *Re Mitchell and St. Michael's Hospital* (1980), 29 O.R. (2d) 185, 112 D.L.R. (3d) 360 (H.C.J.). But see *Strazdins v. Orthopaedic and Arthritic Hospital Toronto* (1978), 22 O.R. (2d) 47, 7 C.P.C. 243 (H.C.J.).

[208] With respect to access to medical records by third parties, it should be noted that several provisions grant access under certain circumstances to particular individuals or groups, such as the Tuberculosis Prevention Service of the Ministry of Health and other research institutes: R.R.O. 1980, Reg. 865, s. 49(7)-(9).

time preserving the anonymity of the parties.[209] This practice conforms, as we have seen, to the canons of the *Code of Ethics*.

But, notwithstanding the general injunction to maintain confidentiality, and the present practice of most artificial conception practitioners to respect the anonymity of those involved in artificial conception procedures, the Commission is of the view that the law should be clarified in certain respects. For example, it is not clear that gamete donors, particularly semen donors, are "patients" for the purpose of the record keeping provisions of Ontario legislation. In addition, given the possibility that an artificially conceived child may, for example, be born with a genetic defect transmitted by a gamete donor, a system of linkage between donors and recipients, including a duty on the part of the attending physician to report such a defect to the affected person or persons, should not be left to the dictates of individual doctors. These and certain other matters relating to the maintenance of, and access to, artificial conception records deserve particular attention in this Report.

7. RESEARCH AND EXPERIMENTATION ON HUMAN GENETIC MATERIAL

In this section, we shall deal briefly with matters relating to research and experimentation on human genetic material. In isolating this particular aspect of medical science, we recognize the large area of overlap between therapy, designed to benefit a patient directly, and pure research or experimentation, designed to acquire knowledge irrespective of its direct application to an individual.[210]

In the context of artificial conception, the question of experimentation arises, for example, where fertilized ova are produced in order to treat infertility but for some reason are not transferred to a woman. Moreover, fertilized ova may be created specifically for the purpose of experimentation, rather than having been produced as a necessary part of a therapeutic artificial conception programme. Or ova may be removed during the course of a hysterectomy.

We turn first to consider the threshold question concerning the propriety of research and experimentation on human gametes and embryos. There is very little in the way of legislation or jurisprudence even remotely relevant to this issue. With respect to professional guidelines, section 46(2)(d) of the *Health Disciplines Act*[211] provides that one of the objects of the College of Physicians and Surgeons of Ontario is "to establish, maintain and develop standards of professional ethics among its members". No specific standards have yet to be set by the College to govern research and experimentation on human gametes and embryos.

---

[209] See *supra*, ch. 2, sec. 3(b)(i).

[210] See, for example, Dickens, "Information for Consent in Human Experimentation" (1974), 24 U. Toronto L.J. 381, at 382; Dickens, "What is a medical experiment?" (1975), 113 Can. Med. Ass'n J. 635; and Medical Research Council, *Ethical Considerations in Research Involving Human Subjects* (Report No. 6, 1978) (hereinafter referred to as "Medical Research Council Statement"), at 6-7.

[211] *Supra*, note 2.

However, it has been reported that ethical guidelines for medical researchers in Canada are in the process of modernization by a committee of the Medical Research Council. It appears that research in the context of human artificial conception will form part of the subject matter of this process.[212]

More recently, The Society of Obstetricians and Gynaecologists of Canada has published an official statement on I.V.F. and embryo transfer.[213] After endorsing the procedure as an ethically acceptable treatment for infertility, the Society expressed the following views:[214]

> The Ethical consideration that has caused the greatest public concern is the experimentation on non-transferred concepti. It is considered ethically acceptable to scientifically examine conceptuses prior to the time development has reached the stage when implantation would normally occur.
>
> The Committee feels that there should be a strong research component in any IVF program. Answers to questions regarding the high failure rate of implantation of concepti and the understanding of early developmental abnormalities of concepti can only be answered by careful study at this very early stage.

While the Society used the term "experimentation" in describing the object of public concern, its actual conclusion seemed to be more limited: it considered it ethically acceptable to "examine" non-transferred embryos, conduct that appears to fall short of experimentation on such material.

Finally, it bears mentioning that Ontario hospitals engaged in artificial reproduction programmes do not seem to have developed standards dealing specifically with experimentation on human gametes and embryos. It would appear that hospital fertility clinics or departments in Ontario implant all fertilized ova; in other words, the practice is not to create a bank of fertilized ova that may be frozen or may be used for experimentation purposes. With respect to the fertilized ova that are to be transferred to women, it seems that Ontario hospitals that have an I.V.F. programme experiment only in terms of the procedure itself, in order to increase its rate of success; they do not conduct experiments on the fertilized ovum with the intention of altering or otherwise manipulating it in some way.

As indicated, few legislative provisions are even tangentially related to experimentation. However, the *Human Tissue Gift Act*[215] does serve to crystallize, at least in part, society's response to certain features of research and experimentation generally. Section 10 of the Act provides as follows:

---

[212] "Ethics rules for research modernized", *The Globe and Mail*, Toronto (July 28, 1984), at 17. The present guidelines appear in Medical Research Council Statement, *supra*, note 210.

[213] The Society of Obstetricians and Gynaecologists of Canada, *Statement on In-Vitro Fertilization and Embryo-Transfer*, published in the Bulletin of the Society, Vol. VI, No. 3, May/June, 1984, at 4.

[214] *Ibid.*

> 10. No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy.

Assuming that semen and ova are body parts,[216] the purchase or sale of such genetic material would be prohibited under the Act. However, as we have said, the more likely situation is that surplus fertilized ova are left in the custody of a hospital or fertility clinic after the successful implantation of the other fertilized ova in a woman participating in an artificial conception programme. In such a case, where the surplus ova have been donated to the custodial authority or abandoned by the woman or couple in question, section [illegible] would not appear to apply, since it deals with dispositions "for a valuable consideration".

Another provision in the *Human Tissue Gift Act* that is relevant to the question of experimentation is section 4(1), dealing with *post mortem* gifts. The section reads as follows:

> 4.-(1) Any person who has attained the age of majority may consent,
>
> (a) in a writing signed by him at any time; or
>
> (b) orally in the presence of at least two witnesses during his last illness,
>
> that his body or the part or parts thereof specified in the consent be used after his death for therapeutic purposes, medical education or scientific research.

Subsequent provisions amplify this section and provide for *post mortem* donations in other situations. In these cases, the Act presumably would serve to legitimize a *post mortem* gift of, for example, frozen or fresh fertilized ova, whether surplus or not, where an intended I.V.F. participant dies leaving such genetic material. Other examples — such as in the case of frozen semen left by a deceased cancer patient — illustrate the possible operation of the provisions in respect of experimentation.

As indicated, the Act does not expressly cover the *inter vivos* donation of a body part for the purpose of experimentation. However, with respect to such donation by a minor, one commentator has stated that "legislative silence seems to imply that removal surgery for experimentation, whether based on purported consent of minor or parent, would be illegal".[217] Precisely why, in a statute that appears to cover a very broad range of situations, "legislative silence" implies that such conduct is unlawful is not made clear.

---

[215] *Supra*, note 111. The Act is also considered *supra*, this ch., sec. 4, in relation to gamete donations.

[216] Given the reference to "blood or blood constituents" immediately after the reference to body parts, it seems reasonable to assume that "blood or blood constituents" are, or were assumed by the drafter to be, a species of body parts. If so, it seems equally reasonable to suggest that gametes are body parts as well.

Not surprisingly, when we turn from legislation[218] to common law, there is a general absence of any relevant jurisprudence on the question of embryonic or gamete experimentation. As a matter of principle, it appears that the law does not accord the same status to a gamete or fertilized ovum as it does to a living child or adult, or even, in some cases, a fully differentiated fetus. The ethical foundation, or explanation, for this view has been expressed in the following manner:[219]

---

[217] Dickens, "Contractual Aspects of Human Medical Experimentation" (1975), 25 U. Toronto L.J. 406, at 416.

[218] Reference should also be made to the *Criminal Code*, R.S.C. 1970, c. C-34. For example, s. 251(1) provides that "[e]very one who, with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence". A question arises whether a person doing research on fertilized ova commits an offence under this section. First, the actual intention of the researcher is not to procure a miscarriage where he is doing research on ova fertilized *in vitro*. Secondly, it seems reasonably clear that there can be no miscarriage where there has been no implantation — a result that would apply irrespective of the manner of fertilization. In this connection, see the Parliamentary Written Answer by Sir Michael Havers, Attorney General of England, respecting whether the use of post-coital contraception violated the abortion law (*Offences Against the Person Act, 1861*, 24 & 25 Vic., c. 100, akin to s. 251 of the Canadian *Criminal Code*). The Attorney General, in refusing to prosecute those persons who prescribed the contraceptive pill, stated that a person who causes a fertilized ovum not to implant has not procured a miscarriage. He stated further as follows:

> It is clear that, used in its ordinary sense, the word 'miscarriage' is not apt to describe a failure to implant - whether spontaneous or not. Likewise, the phrase 'procure a miscarriage' cannot be construed to include the prevention of implantation. Whatever the state of medical knowledge in the 19th century, the ordinary use of the word 'miscarriage' related to interference at a state of pre-natal development later than implantation.

42 *Parl. Deb.*, H.C. (6th ser.), No. 112, col. 237 (May 10, 1983).

Reference should also be made to s. 206 of the *Criminal Code*:

> 206.-(1) A child becomes a human being within the meaning of this Act when it has completely proceeded, in a living state, from the body of its mother whether or not
>
> (a) it has breathed,
>
> (b) it has an independent circulation, or
>
> (c) the navel string is severed.
>
> (2) A person commits homicide when he causes injury to a child before or during its birth as a result of which the child dies after becoming a human being.

While it seems very unlikely that this section would apply, for example, to the removal of ova in order to create, through I.V.F., an embryo upon which research is to be conducted, the conclusion may appear to be different where an ovum is fertilized *in vivo* and flushed out before implantation. It bears emphasizing that the "child" need not exhibit any macroscopic indications of life, such as breathing, in order for the section to apply.

However, it would seem strange to find that a two cell embryo flushed from a woman's body is a "human being" for the purpose of s. 206, when a widely accepted contraceptive device, the I.U.D., operates by destroying just such an embryo. It is arguable, therefore, that the section would not be used in the *in vivo* fertilization case, a situation obviously not contemplated by the drafters of the provision.

> [T]he attribution of absolute protection to the human embryo from its earliest beginning has no long history in Western moral tradition. In the tradition, grounded in Aristotelian thought and science, human status was attributed and protection was accorded, as physical development warranted recognition; and the protection became stronger as the fetus advanced stage by stage towards maturity and birth. Knowing as we do that in the natural process large numbers of fertilised ova are lost before implantation, it is morally unconvincing to claim absolute inviolability for an organism with which nature itself is so prodigal.

From the foregoing description, it may be seen that the law is as much in a formative stage of development concerning research and experimentation on genetic material as it is concerning artificial conception generally. While the *Human Tissue Gift Act* prohibits the sale of gametes and embryos, its focus is essentially narrow: it does not purport to delineate what ought to happen where research and experimentation are conducted on donated or abandoned genetic material. For example, no legislative provisions or guidelines address such critical issues as time limits on embryonic research and the implantation of embryos that have been the object of experimentation.

Moreover, the law does not deal adequately with a separate, but related matter, that is, the means by which human genetic material is acquired for the purpose of research and experimentation. One commentator has suggested that "[t]he principal restraints upon medical research and educational use of human body materials available *inter vivos* stem from methods of acquisition, which must be both lawful and ethical".[220]

We turn, then, to consider such acquisition, or, more specifically, the issue concerning who has the right to control the use of, and, perhaps ultimately, to destroy, human genetic materials. While this question has a dimension extending beyond research and experimentation, given the importance of these activities and their controversial nature we shall discuss the matter here within these narrower confines.

When one considers the question of the control of human genetic material, it is not unreasonable to conclude that the question is affected, if not determined, by the law relating to property or possessory rights. That is, such rights would give control over the genetic material to the person enjoying the property or possessory right. If, for example, a hospital acquired an exclusive property or possessory right to surplus embryos or to ova removed during a hysterectomy, and assuming the legal and ethical propriety of experimentation, presumably it could engage in such conduct notwithstanding the wishes of the person whose gametes were involved.

---

[219] United Kingdom, Royal College of Obstetricians and Gynaecologists, *Report of the RCOG Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer* (1983), para. 13.5, at 13.

[220] Dickens, "The Control of Living Body Materials" (1977), 27 U. Toronto L.J. 142, at 151.

In connection with the issue whether gametes or fertilized ova, as body parts, are properly capable of being dealt with or transferred as species of property, reference may be made to the following views:[221]

> The law's response to laymen's questions on these lines is one of embarrassment, for it has many times been stated by commentators and learned writers that the body and its parts are not property at all, let alone belonging to anyone.[222] This paper attempts to suggest that that view is misleading, if not quite misconceived.

At a later juncture, the commentator stated that "[i]t would be an extremely poor legal system which could not ascribe to such matters having physical substance the capability of being 'property' ".[223]

It was suggested that the fact that a person does not have absolute beneficial "ownership" of an object does not mean that he or she has no "property" or other (for example, possessory) interest in it.[224] Accordingly, even if there are some restrictions on a woman's rights respecting her own ova, presumably some type of interest may still be found in her. And, of course, one person's right or interest in genetic material, however that right or interest is characterized, may permit that person to, for example, donate it to a hospital for experimental purposes, or require it to be destroyed notwithstanding the claims of others to use it for such purposes: that right or interest may well be superior to that of anyone else. The same commentator stated that "[t]he person producing the substance has the first right to it, subject to statute".[225]

In applying the preceding propositions directly to the case of ova and sperm,[226] it was said that, "in principle, to the extent that the genetic material does not result in the creation of a living human being it should be regarded as the 'property' (at least in the sense of there being a best right of possession) of the producer, although this person could transfer or transmit that right to possession to others".[227]

---

[221] Matthews, "Whose Body? People As Property", in Lloyd *et al.* (eds.), *Current Legal Problems 1983* (1983) 193, at 193 (footnote reference deleted).

[222] See authorities cited *ibid.*, at 221, *n.* 2.

[223] *Ibid.*, at 223.

[224] *Ibid.*, esp. at 195, 208 *et seq.*, and 223 *et seq.* For example, under certain circumstances, the *Anatomy Act*, R.S.O. 1980, c. 21, permits the possession of corpses by medical schools for dissection and medical education, even though it has been said that a dead body cannot be the subject of a property right.

[225] Matthews, *supra*, note 221, at 224.

[226] *Ibid.*, at 226-27.

[227] *Ibid.*, at 226. But see s. 10 of the *Human Tissue Gift Act*, discussed *supra*, this sec.,

Assuming that a property right or a right of possession rests in the producer of the human genetic material — and, therefore, assuming that such rights in the material do not automatically pass to the hospital or physician storing or working with it — questions still arise concerning, for example, whether these rights may be lost merely by a failure to assert them or whether, notwithstanding the absence of specific directions, the producer of the ova or semen may correctly assume that the hospital or physician is under a legal duty to destroy the unused material, with perhaps some routine examination by a pathologist, but not experimentation.

The answer to these questions is, at the present time, highly speculative. One commentator, emphasizing the beneficial public policy dimension of research and experimentation, has observed:[228]

> The legal inference of the source's silence and passivity is that his inchoate right to his separated body material is yielded to the hospital .... The proposal favouring the hospital's right is based both on the policy that the hospital's potential for creative use should prevail over a presumption that the silent patient gives possession on an implied condition of destruction, and on observable practice.

The "observable practice" appears to be somewhat more equivocal. Many hospitals store removed body parts in a chemical preservative for a specified length of time after pathological examination. During this time, patients may reclaim their body parts. If, after the lapse of the stipulated time period, no claim has been made for them, they are incinerated. It appears that consent to surgery forms do not make reference to the use or disposal of severed body parts. This practice seems to be consistent with more than one legal theory concerning the locus of a superior proprietary or possessory claim to the material.

But even if some type of research is part of the normal and acceptable practice of a teaching hospital, and assuming at least initial rights in the genetic material to be in its human source, silence on the part of that source does not necessarily mean that that person has, in law, abandoned all rights to the material. Silence does not necessarily mean consent to whatever use the hospital may care to put the material, particularly where silence results in conduct not ordinarily envisaged by the average patient.[229] Arguably, one might assume that

---

which proscribes a *sale* of body parts for, *inter alia*, research purposes. Even if ova, for example, were characterized as a *non-renewable* body part (see, generally, *supra*, this ch., sec. 4(a)), it was said that the person from whom the part was extracted has "the first and best right to possession", with the additional right to transfer this right of possession: Matthews, *supra*, note 221, at 227.

[228] Dickens, *supra*, note 220, at 184. In the United States, see, for example, *Hembree v. Hospital Board of Morgan County*, 300 So.2d 823 (Ala. Sup. Ct. 1974), where it was held that there is no implied term of the contract in the hospital-patient relationship that prevents disposal of the patient's body products without the patient's prior permission.

[229] In *Browning v. Norton Children's Hospital*, 504 S.W.2d 713 (1974), the Kentucky Court of Appeals dismissed an action against a hospital brought by a patient who had a great fear of fire, where the hospital had incinerated his amputated leg. The patient made inquiries 4 weeks after the operation. The Court said that the hospital acted reasonably and that the

there is an implied consent to allow the hospital to use the material for teaching and examination purposes, for example, but not for experimentation. Moreover, if the matter were to be tested in the courts, the very nature of the body parts considered in this Report might persuade courts to impose special, restrictive rules, not applicable to other body parts.

From the preceding discussion, it is fair to conclude that, with respect to the propriety and regulation of research and experimentation on human genetic material, legislation, jurisprudence, and formal professional ethical standards have not kept pace with the rapid and continuing advances in medical science. It is simply not sufficient to prohibit the sale of human genetic material, as the *Human Tissue Gift Act* does, for this deals solely with the means of acquiring the material, rather than the regulation of research activities carried out on it. There must be an unambiguous statement respecting the propriety of research and experimentation on human genetic material. If, for public policy reasons, such activities are to be restricted to particular kinds of institution, this, too, should be made clear. Finally, there should be minimum regulatory guidelines to protect the community from unrestricted experimentation. Given, for example, the justifiable concern respecting the duration of experimentation on human embryos and the implantation of embryos that have been subjected to experimentation, it is desirable to deal with these matters expressly. In short, the law must speak clearly if it is to keep abreast of recent medical developments.

Finally, leaving aside questions concerning the regulation of research and experimentation activities, there is a dearth of jurisprudence respecting the locus of control over human genetic material. Even if one were to assume that such material were the subject of proprietary or possessory interests, the resolution of questions concerning who has control of such material at any particular time — and for what purposes — is suffused with difficult public policy issues that have not been resolved. In this area, the desirability and requirements of scientific

---

patient was negligent in not acting sooner. This case may appear to stand for the proposition that the patient had abandoned all rights in his body parts to the hospital by not giving specific directions. However, the Court made it clear that a "hospital cannot be expected to retain and preserve an amputated extremity indefinitely — it might be diseased, infected, or a health hazard" (*ibid.*, at 715). In other words, public health factors necessitated incineration. Presumably, had a claim or direction been made or given prior to incineration — had the patient not been negligent in delaying, as the Court said he was — such a claim or direction would have been respected by the hospital.

On the other hand, the Court also said that, "when one consents to and authorizes an operation while a patient in a hospital (absent any specific reservation, demand, or objection to some normal procedure), he then and thereby, in effect, accepts all the rules, regulations, and the modus operandi of that hospital" (*ibid.*, at 714). Arguably, then, the patient must act affirmatively to preserve his rights: he must make some "reservation, demand, or objection" to a "normal" hospital procedure. Is experimentation — more specifically, experimentation on human gamete material — a "normal" procedure, in the sense that, where a hospital includes such conduct within its "modus operandi", a patient must positively act to preclude or restrict experimentation, and cannot simply rely on an assertion that experimentation on severed body parts is not normal? The case did not deal with this situation. Indeed, the case is instructive, but nonetheless rather equivocal, concerning the issue under consideration.

exploration compete with ethical considerations relating to the control over one's own body parts. But, again, the law must make a choice, however controversial, for the present uncertainty is unacceptable.

8. SURROGATE MOTHERHOOD: CONTRACTS TO TRANSFER CUSTODY OF CHILDREN AND PARENTAL RIGHTS AND OBLIGATIONS

As we have indicated, of significant concern in this Project has been the controversial issue of surrogate motherhood, where a woman bears a child expressly for the purpose of surrendering custody of that child upon birth to another person or persons. The child may or may not be genetically related to the surrogate mother or to the woman to whom custody is to be transferred under the agreement. Moreover, the child may have no biological connection with any male to whom it will be surrendered upon birth.

Whatever the genetic relationship between the child and the parties to a surrogate motherhood agreement, the means of conceiving the child involve one of the artificial conception techniques described in chapter 2 of this Report. Accordingly, earlier comments in this chapter concerning many of the lacunae in the present law, or the inadvertent treatment of certain relevant issues under the law, are apropos in the context of surrogate motherhood. For example, it will be recalled that the birth of a child in Ontario to a surrogate mother who is married and living with her husband at the time of conception gives rise to a statutory requirement that the particulars of the husband be listed as those of the father of the child. There is a legal presumption, although rebuttable, that the child is the child of the surrogate mother and her husband.[230] As a result, the intentions of the parties and, arguably, the best interests of the child, are not furthered by the existing legal regime. Even the right of the biological father to apply for a declaration that he be recognized in law as the legal father[231] would, aside from being a circuitous means of "legalizing" what is in fact the case, serve to affect only his own relationship to the child; even assuming the voluntary transfer of custody to him and his wife by the surrogate mother, his wife would still have no legal connection with the child. Nor would she be in a more advantageous position where, for example, the surrogate mother was not married or was living separate and apart from her husband at the time of conception: the provisions under the *Vital Statistics Act* would, at most, provide a mechanism by which the father could acknowledge or declare his paternity.

In this section, we shall canvass what is the essential feature of surrogate motherhood arrangements, that is, that the woman who gives birth to the child does not intend to act as the social mother, but, instead, intends that the child be surrendered to another person or persons. It is this transfer of custody, with the parental rights and responsibilities incident thereto, that lies at the heart of the surrogate motherhood controversy. Accordingly, we turn to consider the legal effect of an agreement to transfer custody of a child.

---

[230] *Vital Statistics Act*, *supra*, note 125, s. 6(4). See *supra*, this ch., sec. 5(a).

[231] *Children's Law Reform Act*, *supra*, note 126, s. 4(1). See *supra*, this ch., sec. 5(b).

(a) COMMON LAW BACKGROUND

Historically, the courts in England strenuously disapproved of agreements to transfer custody or parental rights and duties. Many courts refused to enforce such agreements, declaring them void on grounds of public policy in the most emphatic language.

At common law, a father had an absolute right to custody of a legitimate child, even as against the natural mother. His right was not displaced, save where his conduct would endanger the life, morals, or health of the child. That a father possessed this right seemed to flow from his duty to protect and maintain his children, which could be discharged only if he had actual custody.[232]

Equity had power to intervene between parent and child, derived from the prerogative power of the Crown as *parens patriae*. Based on its pre-eminent concern for the welfare of the child, equity was more willing to interfere with the exercise of paternal rights than the common law, which denied a father custody only in extraordinary circumstances. However, it may be said that the best interests of the child generally animated judicial decisions at both common law and equity.

The early cases dealing with transfer of custody arose out of separation agreements in which fathers purported to transfer the custody of their children to their wives. The courts' attitude to these agreements was clear. Contracts to transfer custody were declared to be void as against public policy and unenforceable.[233] The basis of the courts' rejection of these agreements was a belief that, except in extraordinary circumstances, it was in the interests of the child to require fathers to discharge their duties.

However, given the overriding consideration for the child's welfare, some courts did not view this requirement as immutable. In *Hope v. Hope*,[234] the Court considered an action for specific performance of a separation agreement executed between a husband and wife, which provided, *inter alia*, that one of their children would remain in the care of his mother. The Court held the agreement unenforceable, as contrary to the "settled law and policy" of England. Yet, Lord Justice Turner suggested that the rule that a father could not by agreement surrender custody to another was not an absolute rule that admitted of no exception.[235] For example, the general rule would not apply where the control of the father was injurious to the child.[236]

---

[232] See Bromley, *Family Law* (6th ed., 1981), at 276.

[233] See Cairns, *Eversley on Domestic Relations* (5th ed., 1937), at 414; *Lord St. John v. Lady St. John* (1805), 11 Ves. Jun. 525, 32 E.R. 1192 (Ch.); and *Vansittart v. Vansittart* (1858), 2 De G. & J. 249, 44 E.R. 984 (C.A. Ch.).

[234] (1857), 8 De G.M. & G. 731, 44 E.R. 572 (C.A. in Ch.) (subsequent references are to 44 E.R.).

Most of the cases concerned agreements by fathers to surrender custody. However, it was clear that the judicial position that parental rights were not transferable by agreement extended to mothers as well.[237]

Although the case law provided that an agreement by a father to transfer parental rights was void and unenforceable, an apparent exception to the rule was acknowledged where the father had acted upon a purported custody agreement so as to enhance the position of the child. In such a case, some courts were unwilling to allow the father to rescind the agreement and recover custody, because to do so it would disappoint the expectations of his child. This position, it should be noted, was not based on a policy favouring the enforceability of promises, but on a perception of the best interests of the child.[238]

Before leaving our discussion of the jurisprudence in England, reference should be made to the recent decision of *A. v. C.*[239] In that case, the Court was faced with an application for access by the natural father in the context of an abortive surrogate motherhood arrangement. By way of *obiter*, Mr. Justice Comyn stated that the agreement in question was "pernicious", since, he believed, it was for the purchase and sale of a child; accordingly, he said it was void as against public policy.

In dealing with agreements to transfer custody, Canadian courts appear to have demonstrated a somewhat greater degree of flexibility than English courts.[240] While one can find judicial pronouncements, similar to those in England, declaring that such agreements are contrary to public policy, one can also find cases in which these arrangements have been enforced.

For example, in *Roberts v. Hall*, after the trial judge[241] held that the agreement was "contrary to public policy and illegal", the Divisional Court[242] held enforceable a written agreement whereby a father agreed to transfer custody of his young daughter to the child's aunt and uncle, who agreed to bring her up as their own child, in return for their promise that the child be made heir to their property. The agreement was characterized as an arrangement "*bona fide* intended for the benefit of the child", rather than "a colourable attempt to contravene the policy of the law".[243]

---

[235] *Ibid.*, at 577.

[236] See *Swift v. Swift* (1865), 34 Beav. 266, 55 E.R. 637 (Rolls). See, also, *Hamilton v. Hector* (1871), 6 L.R. Ch. App. 701 (C.D.).

[237] See *R. v. Barnardo (Tye's Case)* (1889), 23 Q.B.D. 305 (C.A.), esp. at 310-11, and *Humphrys v. Polak*, [1901] 2 K.B. 385 (C.A.).

[238] See *Eversley on Domestic Relations*, *supra*, note 233, at 428-29.

[239] Unreported (June 20, 1978, H.C.J., Fam. Div.), aff'd *A. v. C.*, unreported (July 18, 1978, C.A.).

[240] For a discussion of the general common law background in relation to custody, see Backhouse, "Shifting Patterns in Nineteenth-Century Canadian Custody Law", in Flaherty (ed.), *Essays in the History of Canadian Law* (1981), Vol. 1, at 212.

[241] (1882), 1 O.R. 388 (H.C.J.).

[242] (1882), 1 O.R. 397 (Div. Ct.).

Chancellor Boyd stated that the general rule prohibiting the relinquishment of custody was subject to two exceptions, each arising out of a concern for the benefit of the child. The first exception was where the conduct of the father indicated that a failure to enforce the agreement would endanger the child.[244] The second exception arose where the agreement to transfer custody was concluded with the intention of conferring benefits on the child. In such a case, a court would enforce the agreement.[245] Indeed, early in this century the Supreme Court of Canada recognized that certain custody agreements, where the purpose was to benefit the child, were not illegal.[246] However, later Ontario cases bearing upon this issue took a more orthodox approach.[247]

(b) THE PRESENT POSITION IN ONTARIO

In this section, we shall consider the present Ontario position respecting agreements to transfer custody of a child. Before doing so, however, reference should be made to the notion of what is a child and a parent. Section 1(1) of the *Children's Law Reform Act*,[248] dealing with the question of parentage and the status of children, provides, *inter alia*, that, "[s]ubject to subsection (2), for all purposes of the law of Ontario a person is the child of his or her natural parents ...". Subsection (2) deals with the consequences of an adoption order that has been made under the *Child Welfare Act*, namely, that the child becomes the child of the adopting parents, "as if they were the natural parents". In other words, except in the case of adoption, it is not possible at present to alter parentage or the status of a child, whether by contract or otherwise.

---

[243] *Ibid.*, at 407.

[244] *Ibid.*, at 405. Boyd C. cited *Swift v. Swift*, *supra*, note 236.

[245] *Supra*, note 242, at 405-06 (footnote references deleted).

[246] *Chisholm v. Chisholm* (1908), 40 S.C.R. 115. The Supreme Court, by a majority (3:2), upheld an agreement whereby a widow, in return for a promise to pay her $500 annually, agreed to transfer custody of her young daughter to the child's paternal grandfather so that he might be appointed her legal guardian. The intention of the grandfather had been to ensure that his granddaughter was educated in a convent. In *Chisholm*, Fitzpatrick C.J. summarized the argument as follows (*ibid.*, at 117):

> I can find nothing in the agreement itself or in its surrounding circumstances as brought out by the evidence to justify the contention that the family agreement which is attacked was only a scheme to benefit the mother, or that she had any interest which conflicted or could be in conflict with that of the child.

Mr. Justice Davies viewed the "family arrangement" as stipulating for a limited transfer of parental rights and duties, which would leave the mother subject to her "natural duties", save for those involved in the transfer of legal guardianship to the grandfather under the Nova Scotia legislation (*ibid.*, at 122).

[247] See, for example, *Re Davis* (1909), 18 O.L.R. 384 (H.C.J.), and *Re Orr*, [1933] O.R. 212 (C.A.). See, also, *Re Hutchinson* (1913), 28 O.L.R. 114 (C.A.), rev'ing (1912), 26 O.L.R. 601 (Div. Ct.), where Riddell J. distinguished *Roberts v. Hall*, *supra*, note 241, and *Chisholm v. Chisholm*, *supra*, note 246.

[248] *Supra*, note 126.

Turning to the issue of the transfer of custody, it first bears emphasizing that our concern is not simply with the physical transfer of a child from one person to another. Transferring custody involves far more than a change of residence. Section 20(2) of the *Children's Law Reform Act* provides that a "person entitled to custody ... has the rights and responsibilities of a parent in respect of the person of the child and must exercise those rights and responsibilities in the best interests of the child". As we shall see, while the precise nature of most of these "rights and responsibilities" is not made express, some are specifically dealt with in legislation.

In Ontario, the question of the validity of agreements to transfer custody or parental rights and responsibilities has received specific legislative attention in several contexts. First, Part IV of the *Family Law Reform Act*,[249] which deals with domestic contracts, addresses the circumstances in which a man and a woman may enter into an agreement respecting the custody of their children. Secondly, Part III[250] of the *Children's Law Reform Act* addresses, among other things, the matter of custody. Finally, Part III of the *Child Welfare Act*[251] deals, *inter alia*, with agreements in relation to the placement of children for the purposes of adoption. Where these statutes are not applicable, it would appear that the common law would continue to govern an agreement purporting to transfer custody.

Under the *Family Law Reform Act*, the right of persons to deal with custody and access is narrowly circumscribed. Part IV of the Act deals with "domestic contracts", which term is defined in section 50 to mean marriage contracts, separation agreements, and cohabitation agreements. Rights of custody and access may be dealt with only in a separation agreement under section 53.[252]

---

[249] *Supra*, note 127.

[250] As enacted by the *Children's Law Reform Amendment Act, 1982*, S.O. 1982, c. 20.

[251] *Supra*, note 58. See the new *Child and Family Services Act, 1984*, *supra*, note 58, Part VII.

[252] Section 53 of the *Family Law Reform Act*, *supra*, note 127, provides:

> 53. A man and a woman who cohabited and are living separate and apart may enter into an agreement in which they agree on their respective rights and obligations, including ...
>
> (d) the right to custody of and access to their children ....

Aside from public policy considerations, it is not at all likely that s. 53 would apply to agreements to transfer the custody of a child under a surrogate motherhood arrangement. It would be very unusual, for example, that a surrogate mother and the biological father would have cohabited so as to make s. 53 even theoretically relevant.

The only other *Family Law Reform Act* provision concerning agreements affecting children is s. 58, which governs paternity agreements. It does not deal with custody matters.

However, even in this situation, the agreement cannot bind a court. Section 55 (1) provides as follows:

> 55.-(1) In the determination of any matter respecting the support, education, moral training or custody of or access to a child, the court may disregard any provision of a domestic contract pertaining thereto where, in the opinion of the court, to do so is in the best interests of the child.

It should be noted that, by giving the court power to ignore any provision respecting custody in a separation agreement, the *Family Law Reform Act* was not enacting new law, but was merely casting the common law position in statutory form.[253]

Not only does the *Family Law Reform Act* deal with the situations in which custody can and cannot be transferred, it also creates, by section 16(1), an obligation on a parent to provide financial support to his or her unmarried child who is under the age of eighteen.[254] It should be noted that this financial duty is not dependent upon the locus of custody, but arises exclusively from the relation of parent and child.[255]

We now turn to Part III of the *Children's Law Reform Act*, which also deals with custody. Section 20(1) provides that, except as otherwise provided in Part III, the father and the mother of a child are equally entitled to custody of their child. As we have seen, section 20(2) provides that a "person entitled to custody ... has the rights and responsibilities of a parent in respect of the person of the child and must exercise those rights and responsibilities in the best interests of the child".

Nowhere in the Act is there a definition or explanation of the phrase "rights and responsibilities of a parent in respect of the person of the child". Arguably, this would leave the content of those rights and responsibilities to be determined by the common law[256] and other Ontario statutes.[257] Nor are the words "mother", "father", and "parent" defined in the Act. However, we have already noted that section 1 of the Act states that, except where an adoption order has been made under the *Child Welfare Act*, for all purposes of the law of Ontario a person is the child of his or her natural parents.

The *Children's Law Reform Act* provides that the rights and responsibilities of a parent may be exercisable by one person, even though more than one person is entitled to custody. Section 20(3) and (4) provides as follows:

---

[253] See *Clark v. Clark*, [1952] O.W.N. 671 (H.C.J.), at 671-72, respecting the common law position.

[254] An exception is made in respect of "a child who, being of the age of sixteen years or over, has withdrawn from parental control": *Family Law Reform Act*, *supra*, note 127, s. 16(2).

[255] See discussion *supra*, this sec., concerning this relation.

[256] For a discussion of parental rights and duties, see Cretney, *Principles of Family Law* (3d ed., 1979), at 431-38; Eekelaar, "What are Parental Rights?" (1973), 89 L.Q. Rev. 210; Maidment, "The Fragmentation of Parental Rights" (1981), 40 Camb. L.J. 135; and Hall, "The Waning of Parental Rights" (1972B), 31 Camb. L.J. 248.

[257] See s. 16 of the *Family Law Reform Act*, *supra*, note 127, discussed *supra*, this sec.

> 20.-(3) Where more than one person is entitled to custody of a child, any one of them may exercise the rights and accept the responsibilities of a parent on behalf of them in respect of the child.
>
> (4) Where the parents of a child live separate and apart and the child lives with one of them with the consent, implied consent or acquiescence of the other of them, the right of the other to exercise the entitlement to custody and the incidents of custody, but not the entitlement to access, is suspended until a separation agreement or order otherwise provides.

Given the hostile attitude of the common law to agreements to transfer custody, section 20(4) may be seen as overturning this strict approach, at least to some extent. One question that may be raised is whether this statutory exception to the common law is broad enough to cover surrogate motherhood agreements.

From the language of section 20(4), it seems that the section could be read to apply to a surrogate motherhood arrangement: the biological parents of the child would, in fact, be living separate and apart and the child would be living with the father with the consent of the surrogate mother. If section 20(4) were applicable, and if the surrogate mother gave her child to the biological father pursuant to the arrangement, her "right ... to exercise the entitlement to custody and the incidents of custody" would be "suspended". Should she subsequently wish to take the child back, she would be precluded from doing so, and would be forced to apply for custody.

However, despite the language of section 20(4), it is very unlikely that that provision was intended to deal with, or would be applied to, formal, written agreements of the kind involved in a surrogate motherhood arrangement.[258] Moreover, given the fact that the *Family Law Reform Act* provides that even a married, cohabiting couple cannot address the right to custody of their children in a "marriage contract",[259] it is most improbable that section 20(4) of the *Children's Law Reform Act* would be interpreted to confer what amounts to a higher right on the parties to a surrogate motherhood arrangement. Finally, it may be contended on public policy grounds that section 20(4) should not be the means used to give legal effect to the purported transfer of custody under a surrogate motherhood agreement.

---

[258] It bears mentioning that the marginal note to s. 20(4) refers to the situation "[w]here parents separate".

[259] Section 51(1) of the *Family Law Reform Act, supra*, note 127, provides:

> 51.-(1) Two persons may enter into an agreement, before their marriage or during their marriage while cohabiting, in which they agree on their respective rights and obligations under the marriage or upon separation or the annulment or dissolution of the marriage or upon death, including,
>
> (a) ownership in or division of property;
>
> (b) support obligations;
>
> (c) the right to direct the education and moral training of their children, but not the right to custody of or access to their children; and
>
> (d) any other matter in the settlement of their affairs.

The *Child Welfare Act*[260] is yet another statute affecting agreements to transfer the custody of children. Part III of the Act establishes a comprehensive scheme for the adoption of children in Ontario, a scheme designed to ensure that the placement and subsequent adoption are in the best interests of each child. A major feature of the legislation is that, except generally in the case of adoption by a close relative or a step-parent, the placement of a child for the purpose of adoption is always subject to some form of state intervention.

Section 65 of the Act limits the persons who may lawfully place a child for adoption. This provision reads:[261]

> 65.-(1) No person other than an adoption agency or licensee under subsection 60(5) shall,
>
> (a) place or cause to be placed a child under eighteen years of age with another person; or
>
> (b) take or send or attempt to take or send any child under eighteen years of age who is a resident of or who was born in Ontario, out of Ontario, for the purpose of adoption.
>
> (2) No person shall receive a child under eighteen years of age for the purpose of adoption without the prior approval of a Director under subsection (7).
>
> . . .
>
> (4) Subsections (1), (2) and (3) do not apply to,
>
> (a) the placement of a child with a relative of the child or with the spouse of a parent of the child; ...

The prohibition set out above would not appear to apply to a transfer of custody of a child from a surrogate mother to a natural father and his wife. The father would not, of course, be receiving his own child "for the purpose of adoption". The wife would be "the spouse of a parent of the child".[262]

Section 67 of the Act prohibits payments in connection with adoption. It provides as follows:[263]

> 67.-(1) Subject to subsection (2), no person, whether before or after the birth of a child, shall make, give or receive or agree to make, give or receive a payment or reward for or in consideration of or in relation to,
>
> (a) the adoption or proposed adoption of the child under this Part;

---

[260] *Supra*, note 58. See the new *Child and Family Services Act, 1984*, *supra*, note 58. Part VIII of the latter statute deals with adoption.

[261] See, also, *Child and Family Services Act, 1984*, *ibid.*, s. 135.

[262] Similar language appears in the *Child and Family Services Act, 1984*, *ibid.*, s. 135(1) ("for adoption") and s. 135(8)(a) ("a spouse of the child's parent").

[263] See *ibid.*, s. 159.

> (b) the giving of consent or the signing of an instrument of consent to the adoption of the child under this Part;
>
> (c) the transfer of the custody or control of the child with a view to the adoption of the child under this Part; or
>
> (d) the conduct of negotiations or the making of arrangements with a view to the adoption of the child under this Part.
>
> (2) Subsection (1) does not apply to the payment of expenses of an adoption agency or licensee under subsection 60(5) or the payment of legal expenses in connection with an adoption or proposed adoption under this Part.

Whether this prohibition would apply to render surrogate motherhood agreements illegal or void would appear to depend on the nature of the arrangement. If the arrangement involved only a transfer of custody from the natural mother to the natural father, without any intention on the part of another person to adopt the child, the prohibition presumably would not apply. If, however, the arrangement involved a transfer of custody by the natural mother to the natural father and his spouse, with a view to adoption by the latter, it would appear that, certainly in relation to the planned adoption, the prohibition would apply, and the contract therefore would be illegal. However, it should be observed that, if the surrogate mother were to agree to give the child to the natural father and his wife without accepting any payment, section 67 would not apply. Owing to the broad language of the section, it would seem that only the complete absence of any payment, even in relation to medical and other expenses, would be in conformity with its provisions.

If a contract with a surrogate mother is simply an agreement to transfer custody to the natural father, rather than an agreement in connection with an adoption, we are thrown back into the realm of the common law and, perhaps, to other Ontario statutes. With respect to the common law, as we have seen, the courts have long held that, subject to very few exceptions, parental rights and responsibilities are inalienable and incapable of transfer as a matter of contract. With respect to legislation, except in the context of a separation agreement, and except for the provisions of section 20(3) and (4) of the *Children's Law Reform Act*, no statute seems to contemplate or sanction the consensual transfer of parental rights and responsibilities by individuals.[264] And, even in respect of separation agreements and section 20(3) and (4), any arrangement concerning custody may be disregarded by a court where it is in the best interests of the child to do so. Moreover, in none of these cases can the agreement of the parties alter the fact of parentage[265] nor the statutory financial support obligations that arise as a result.[266]

While a surrogate motherhood agreement may not be enforced as a matter of contract law, the existing legal regime does not make it completely impossible to give effect to the wishes of the parties to such an agreement. There are procedures by which a child, born or about to be born to a surrogate mother, might be "naturalized" in the care and custody of the prospective social parents, at least where the social father is also the biological father. The focus of attention here is not on the validity or enforceability of a surrogate motherhood agreement, but on the steps that may be taken today where a child is born or about to be born and the surrogate mother is willing to transfer the child.

---

[264] But see *Children's Law Reform Act*, *supra*, note 126, s. 62, which deals with the appointment by will of a person to have custody of a child after the death of the appointor.

[265] See *ibid.*, s. 1(1), discussed *supra*, this sec.

[266] See *Family Law Reform Act*, *supra*, note 127, s. 16, discussed *supra*, this sec.

Leaving aside the matter of birth registration, the first stage in regularizing the status of the child *vis-à-vis* the social parents would be for the social father — who, for our purposes, is the biological father as well — to obtain a declaratory order of paternity and a custody order under the *Children's Law Reform Act*, having first obtained the agreement of the surrogate mother not to contest the orders.[267]

After having concluded these processes, step-parent adoption proceedings would be commenced by the natural father's spouse, with a consent filed by the surrogate mother, unless an order dispensing with consent has been obtained.[268]

---

[267] See Parts II and III of the *Children's Law Reform Act*, *supra*, note 126, concerning paternity and custody, respectively. Of course, as we have seen, no custody order is final.

[268] With respect to dispensing with consent, see *Child Welfare Act*, *supra*, note 58, s. 69(7) and (8), and *Child and Family Services Act, 1984*, *supra*, note 58, s. 132.

It should be noted that, under Part III of the *Child Welfare Act*, *supra*, note 58, step-parent adoptions are given very different treatment than stranger adoptions. Many of the controls that are imposed to ensure that the placement, and later the adoption, of the child are in his or her best interests do not apply to a step-parent adoption. The basic statutory scheme in respect of stranger adoptions is to provide that placement for the purpose of adoption may be effected only by an adoption agency or a person licensed to place a child. In the case of a private adoption agency or a licensed person, the approval of the Director of Child Welfare must be obtained, after a homestudy has been made by a qualified person. Neither prior approval nor a prior homestudy is required for the placement of a child with the spouse of a parent of the child. (*Ibid.*, s. 65(3), (4)(a), and (6). See, also, *ibid.*, ss. 73 and 74.) There is no requirement of a probationary period of residence before which an application for an adoption order can be made: *ibid.*, s. 75(1)(a) and (5). The parents may apply immediately to the Provincial Court (Family Division) where they reside. However, while a report on the "adjustment of the child in the home of the applicant" is normally not required, the court may direct that such a report be prepared: *ibid.*, s. 75(4) and (5).

While the procedure governing step-parent adoption has been simplified in an effort to ease adoption, the basic practice remains unaltered, except where particular circumstances warrant otherwise. Accordingly, a step-parent wishing to adopt the child of his spouse must ensure that the requisite consents are obtained properly, or persuade the court to dispense with them. The hearing of the application for the adoption order is governed by the same procedure. Most importantly, before an adoption order is made, the court must be satisfied that the order will be in the best interests of the child. (See *ibid.*, ss. 69 *et seq.*)

With respect to step-parent adoptions under the new *Child and Family Services Act, 1984*, *supra*, note 58, see, for example, s. 135 (esp. s. 135(8)), s. 140(2)(c), s. 143 (esp. s. 143(6)), and s. 146.

However, a myriad of risks and problems abound with respect to how the social parents obtain legal custody of the surrogate mother's child. Critical here is the cooperation of the surrogate mother; otherwise, court intervention is inevitable, with its attendant uncertainty.

At the birth registration stage, where the surrogate mother is single or where she is married but was living separate and apart from her husband at conception, it would be possible to have the particulars and surname of the natural father registered under the *Vital Statistics Act*. However, the Act requires a formal "request" by both the mother and the father.[269] Moreover, we understand that, in practice, the Registrar General requires the mother to have been living separate and apart from her husband for at least one year. While it is difficult to see how this gloss on section 6(5)(a) of the Act is warranted, the practice would certainly restrict the utility of this provision in the context of surrogate motherhood.

In order to expedite proceedings at the paternity order and custody order stages, consents would also have to be sought from the surrogate mother and, if she is married, an affidavit would have to be obtained from her husband, affirming that he has had no sexual relations with his wife for a stipulated period before and after the insemination. Consents to a custody order would also be sought from the natural father and his wife. Again, cooperation is essential to avoid problems.[270] The same applies in the case of an adoption by the father's wife.

Even though, in some cases, the court may dispense with consent, it hardly needs emphasizing that the route just described is highly circuitous, even if the outcome were always predictable and always a manifestation of the expectations and wishes of all the parties. One needs only to envisage a change of mind by the surrogate mother just prior to the final stage. She might do so either because she now wishes custody of the child or because she has not been paid by the social parents and believes, probably rightly, that she cannot obtain redress in the courts.

The surrogate mother's unwillingness to cooperate could lead to protracted proceedings respecting custody of the child. The result of such proceedings would by no means be easily predictable, even leaving aside the fact that no custody order is final. More importantly, however, any dispute concerning the child could be extremely disruptive to whichever family obtains custody and, therefore, could detrimentally affect the environment in which the child is placed. In addition, even where the social parents gain custody, we have seen that the outcome still would not meet the expectations of these persons: the surrogate mother would remain a parent of the child and would continue to be under a statutory obligation to support the child. Indeed, the status of parent and the attendant financial obligation would remain unaffected even if there were no legal impediments to the transfer of custody as such under a surrogate motherhood arrangement.

---

[269] *Vital Statistics Act*, *supra*, note 125, s. 6(5) and (8).

[270] It should be noted that s. 69(1) of the *Children's Law Reform Act*, *supra*, note 126, provides that, "[u]pon the consent of the parties in an application under [Part III], the court may make any order that the court is otherwise empowered to make by [Part III], subject to the duty of the court to have regard to the best interests of the child".

9. CONCLUSION: THE CASE FOR REFORM

In this chapter, the Commission has set forth the extent to which the common law, existing statutory and regulatory provisions, and professional rules of conduct may bear on the use and consequences of the new reproductive technologies in Ontario. At the outset, we cautioned that the "law" in this area is, in a sense, astigmatic — in the main, ignoring or inadvertently applying to the various legal issues arising from the growth of artificial conception services. While the relatively recent advent of these services goes some distance to explain the present state of affairs, the novelty of at least some of the procedures is rapidly diminishing. As a consequence, hitherto reasonable explanations for the dearth of law in the area of artificial conception are beginning to wear thin.

The Commission is quite aware, as we said in the Introduction to this chapter, that the fact that legislation does not speak directly to a certain matter is not, in itself, a damning criticism necessitating immediate remedial action. Silence may well reflect continuing, deep-seated controversy, so that there may be a justifiable wish to permit the law to develop without legislative fetters. Even inadvertent solutions may be equitable responses — a manifestation of the capacity of the legal regime, created to deal with one set of circumstances, to grow and flourish in a new milieu.

On the other hand, the Commission is acutely conscious of the pervasive notion in many circles that the dictates of medical science, when followed to their logical extremes, will lead inexorably to horrors hitherto characterized as fantasy or science fiction. The spectre of cloning, wholly "test tube" babies, genetic engineering and manipulation — these and other fears frequently feed the view that the only proper response of the law in this area is prohibition and criminalization.

While, like others, we are seriously concerned about the nature and implications of certain types of medical and other related research and experimentation, we do not subscribe to this rather cataclysmic, certainly pessimistic, view. The automatic invocation of "logical extremes" and "worst case scenarios" is not, of course, unique to the present context. But, as a precept for action, these arguments must be viewed with extreme caution; they ought not to animate the proper reaction of the law to all developments in the field of medicine. Keeping pace with new and beneficial scientific advances does not thereby make the law an accomplice with regard to those facets of science unacceptable to the community. The law need not meekly trim its sails to accommodate such unwanted developments. Law and law reform comprehend more than merely wholesale endorsement or outright prohibition; as a manifestation of the perceived needs and wishes of the community, they can also, for example, limit or actively facilitate, encourage, or discourage certain kinds of activity to one degree or another. The Commission's reaction to, and perception of, the present law and its adequacy, insofar as it relates to the new reproductive technologies, largely mirrors this more flexible approach to what we believe to be the proper role of the law in this area.

Some issues are of such fundamental importance to parents, children, and third parties that they no longer ought to be left to the uncertainties and vicissitudes of evolutionary legal development. Perhaps the most obvious example concerns the status of an artificially conceived child. Leaving aside the contentious issue of surrogate motherhood, should the law expressly acknowledge the social reality of a child conceived with the use of donor gametes, so that the social parents are recognized in law as the only parents? Or should the gamete donor, the biological parent, who is almost invariably, but not always, anonymous, be treated in law as a parent, with all the rights and responsibilities attendant upon such a role? Should the rules respecting birth registration further acknowledge the social realities and reflect the intentions and expectations of all the parties? Is society well served by legislation that basically ignores artificial conception in this context and even, occasionally, encourages subterfuge and prompts individuals to evade the strictures of the law, for example, by registering children to suit their own predilections?

In the vast majority of cases involving an artificially conceived child where donor gametes are used, the child will have, and will need to have, no legal or other connection with the donor. While the question is controversial, and the perception of the best course to follow has been slowly changing, the continued secrecy respecting the child's origins and the anonymity of the donor are generally thought to be of substantial importance to the stability of the family and the welfare of the child. For a good many children, to be confronted at some point with the existence of the donor, or with the donor himself, may well be highly disruptive. The same may be said where a hitherto unknown donor is permitted to demand parental rights *vis-à-vis* the child.

As in the case of legal status, we are of the view that the law must speak clearly and directly to other matters relating to the place of artificial conception in our society. Our recommendations for reform with respect to such issues as eligibility for participation in an artificial conception programme, the selection of gamete donors, and the nature of, and access to, medical records respecting A.I.D. and I.V.F., are animated by a wish to clarify and reform the law and by a dominant concern for the well-being of artificially conceived children.

Perhaps nowhere is this concern most prominent than in the case of surrogate motherhood. While notions of "womb leasing" and "baby buying" instinctively affect our reaction to this phenomenon, a central theme in our deliberations has been a sensitivity to the wider issue relating to the best interests of the child.

The Commission's review of written submissions made to it, and the discussions that took place at Advisory Board meetings and elsewhere, have heightened our awareness of the strongly held views expressed by both opponents and proponents of surrogate motherhood. While a resolution of the issues involved cannot placate all members of the community, there is at least a growing consensus that the indifference of the present law ought no longer to prevail. Proponents clearly wish to see the enactment of express facultative provisions that would legitimize and render enforceable surrogate motherhood arrangements. Opponents seek outright prohibition, with appropriate sanctions, or at least no change in the present regime. But that regime is frequently an expensive and emotionally draining trap: it offers the potential of substantial risks and penalties for all participants.

It is not intended to anticipate here our subsequent discussion of surrogate motherhood. Suffice it to state our opinion, shared by many persons of diverse views, that the present state of the law must not continue. If law is, in part at least, a body of norms by which society believes it ought to be governed, it cannot afford to ignore a development potentially of so major — and so troubling — a proportion.

This last admonition applies not simply to surrogate motherhood, but, in the end, to all facets of the new reproductive technologies. In relation to these technologies, the vision of the present law is uncomfortably out of focus; indeed, it simply has been overtaken by events. To a significant degree, the existing legal regime cannot escape the confines of the natural reproduction mould. And the search for doctrine that is even remotely relevant to the many serious, complex questions raised in the context of artificial conception involves arduous and generally fruitless legal circumnavigation around frequently foreign principles. It is this uncertainty in the legal implications of various activities — particularly, but not exclusively, in relation to status, parentage, and surrogate motherhood — that pervades the law and practice relating to the use of the new reproductive technologies. A broad cross-section of society, from lawyers to doctors, social workers, ethicists, and others, has decried the absence of clear legal rules to guide the actions of all persons participating, or wishing to participate, in artificial conception programmes. Accordingly, we believe that the law must be re-examined and refashioned. It must reflect the benefits of the new technologies and the reasonable hopes of infertile men and women, while at the same time guarding against those excesses perceived to be injurious to the fabric of society.

CHAPTER 4

ALTERNATIVE APPROACHES TO REFORM

1. INTRODUCTION

In chapter 2 of this Report, we considered the incidence and causes of infertility and discussed several typical responses to this problem. We explained that, while many persons may find relief by undergoing what may be called conventional therapy, such as drugs or surgery, some must seek other means if they are not to remain childless. In the latter case, the steady growth and success of artificial reproduction technologies have offered new hope.

Yet, as we have seen in chapter 3, the legal regime within which the new reproductive technologies operate is, to a large extent, fraught with ambiguities and obstacles. It will be recalled that the present law, in the main reflecting a world in which natural reproduction is taken for granted, responds only haphazardly to the new artificial conception technologies. We need refer only to the uncertain legal status of artificially conceived children as an illustration of the deficiencies and gaps in existing law.

Accordingly, while recognizing the continuing tension between proponents and opponents of the recent advances in medical science that are the subject matter of this Report, the Commission has come to the conclusion that the law can no longer afford to turn a blind eye to artificial reproduction. Uncertainty in the law would, alone, be sufficient to prod us into action. Since a substantial, and growing, number of persons now turn to artificial conception to relieve frustrations associated with childlessness, the law cannot simply ignore them: to do so would be to perpetuate the legal void respecting their activities and the consequences of these activities. And, most importantly, we see the present state of affairs as manifestly unfair to the resulting children. Surely they ought not to bear the burden placed on them by a seemingly indifferent legal system.

But, having outlined the deficiencies in that system, and before we offer our recommendations for reform, it is essential that we consider, from a conceptual standpoint, the basic alternative approaches to reform in the area of artificial conception. To decry the present state of the law *vis-à-vis* the new reproductive technologies is not an adequate response. A determination of the shape of the future legal regime in respect of these technologies requires us to examine certain fundamental approaches to law reform in this area. Put another way, we must consider the extent, if any, to which the state can and should intervene in the decision-making of individuals and in the consequences of their decisions.

No doubt, this kind of conceptual, philosophical inquiry ought to animate and preface proposals for reform in any area of concern. Yet, it should be emphasized that the subject matter of this Report touches upon an extremely personal, sensitive aspect of our lives. The question of conception alone — of introducing a child into a family — leaving aside associated questions relating, for example, to the donation of gametes, would give us sufficient reason to pause and reflect on whether, in so critical an area, we wish to see our privacy compromised by the state. And when we turn from artificial insemination and *in vitro* fertilization to surrogate motherhood, the broad moral, ethical, and legal issues become even more pronounced and troubling.

The submissions made to the Commission illustrate graphically the divergent perceptions and views prevalent in the community. The opinions expressed deserve, and have been given, very serious attention. As we have said, the subject matter of this Report is highly personal and controversial, and to concentrate exclusively on strict principles of logic, without due regard to what may be called the limits of tolerance of the community, would be folly. These perceived limits, grounded in part on certain fundamental fears that may or may not be well-founded, as well as on the practicalities of state intervention, must all be weighed in the balance.

On the other hand, we are constrained to caution against any wholesale abandonment of the view that the law may, and should, act as a progressive, normative guide, not simply a reflection of present community standards. When we consider state intervention in the case of the new reproductive technologies, we may view the issue, at least in part, as a privacy matter. And when the law deals with matters of personal privacy, it frequently swings its pendulum in favour of individual interests. This issue of personal privacy is critical to our study, and any wish on the part of a segment of society to constrict or limit the ability of individuals to choose whatever method they wish to bring a child into the family, and to regularize their relationship with that child, must be balanced against the human costs attending such intervention. The law may reflect the community's level of tolerance; but it may also stretch or fashion it in the interests of a worthy goal.

For the purpose of our conceptual analysis in this chapter, we shall differentiate between two fundamental approaches to reform, representing the two extreme points on what is clearly a continuum. One basic approach we shall term the "private ordering" approach, where the legal regime is designed to give effect to the intentions of the parties. The other basic approach we shall call the "state regulation" approach, where the free choice of the parties does not determine what they may do or the consequences of their actions, but where the state actively intervenes to set mandatory normative standards of conduct. With the latter approach, there are certain ancillary matters that must be addressed. For example, how should the state attempt to persuade people to comply with the rules of behaviour to which adherence is deemed essential?

It bears mentioning here that the so-called private ordering model — exemplified, for example, in the case of one's choice to conceive children by natural reproduction — does not necessarily eschew legislative initiatives. Statutory provisions may indeed be required to give effect to, or preclude interference with, the wishes of individuals. This type of legislation differs from that contemplated by the state intervention approach in its essentially facultative animus: it does not, in effect, tell people what to do or not to do, but serves to facilitate their activities where necessary.

We also wish to note that the two basic approaches set forth in this chapter represent conceptual paradigms of how the law might deal with reproductive choices and their consequences. Accordingly, they each provide a theoretical model against which we may measure the kind of legal regime that ought to govern our conduct. However, a consideration of these general approaches is but one stage in the development of our proposals for reform: it is necessary to determine whether this macroscopic approach to law reform — where all aspects of the subject matter are governed by the same broad conceptual approach — is appropriate in the context of artificial conception. Indeed, it may become clear that the special characteristics of the various artificial reproduction technologies, or certain facets of these technologies, must be dealt with differently. In other words, the legal regime governing such matters need not necessarily be uniform and all-embracing; rather, a more flexible approach, sensitive to the requirements of different aspects of the problem in different ways, may be desirable. Such a hybrid approach may, then, marry aspects of the private ordering and state regulation approaches, and even leave room for common law evolution and for the development of normative guidelines outside the Legislature.

2. THE "PRIVATE ORDERING" APPROACH

As we have indicated, the private ordering approach envisages a basically facultative, nonjudgmental legal regime, where, either actively or passively, the law permits people to arrange their affairs as they see fit. Having regard to the fact that the subject matter of this Report concerns the introduction of a child into the family — and, therefore, raises the question whether there should be any interference with the decision to have recourse to artificial conception — it is appropriate that we look to natural reproduction as a manifestation of a *laissez-faire* private ordering approach largely unaffected by restrictive or prohibitory state intervention.

It is a basic legal postulate in Canada that the state does not intervene in the decisions of adults to conceive children by natural means. Society tolerates the risk that "unsuitable" persons may conceive children by such means, and does not invoke a "best interests of the child" principle to prevent or limit natural reproduction. The law does not prescribe who may be a parent or by whom a woman may choose to become pregnant. In other words, with respect to conception, the legal model of natural reproduction centres upon private decision-making and state non-intervention.[1]

Even when we move beyond the strict confines of conception, and deal with the raising of children, the law does little to interfere with the decisions of individuals. Child welfare legislation does, of course, mandate state intervention where there has been a judicial determination that a child is "in need of protection".[2] However, such legislation does not establish general norms or standards by which to measure and monitor the ordinary parental activities of all members of society. Rather, in section 19(1)(b) of the *Child Welfare Act*, "child in need of protection" is defined in terms of what may be called specific kinds of wrongful behaviour; it applies only on an *ad hoc* basis in respect of particular children who, in the court's opinion, need special protection.

Similarly, as we have seen,[3] courts may review parental arrangements respecting child custody in separation agreements and may always hear applications for the custody of children, at which time the courts are required to consider the best interests of the children as paramount.[4] Courts intervene, however, only where family ties break down in some manner — for example, during divorce proceedings — and then only at the initiative of an aggrieved party. Before then, parents who may, in fact, be unsuited to raise children retain custody or have rights of access through implicit or express consent.

In principle, parental rights run in tandem with parental responsibilities, and parents are both entitled and bound to take charge of their children, unless courts are moved to act in order to limit or sever the link. Courts are not required to be called upon to recognize natural parentage; they intervene to resolve paternity disputes only in the event of disagreement.

---

[1] Society does, however, attempt to reduce the opportunities for some persons to conceive children. For example, young persons, and especially females, have been discouraged from engaging in sexual relations. In addition, laws have been passed protecting young persons from exploitation. Finally, statutory provisions establishing a minimum age of marriage may reflect, at least in part, society's notion concerning the age at which persons could reasonably be expected to shoulder the burdens of parenthood.

[2] See Part II of the *Child Welfare Act*, R.S.O. 1980, c. 66, s. 30. There are *dicta* to the effect that even an unborn child may be a child in need of protection for the purpose of the present Act: see *Re Children's Aid Society for the District of Kenora and J.L.* (1981), 134 D.L.R. (3d) 249 (Ont. Prov. Ct. (F.D.)), cited with approval in *Re Superintendent of Family and Child Service and McDonald* (1982), 37 B.C.L.R. 32, 135 D.L.R. (3d) 330 (S.C.).

See, also, Part III of the new *Child and Family Services Act, 1984*, S.O. 1984, c. 55. During the final editing of this Report, the *Child and Family Services Act, 1984*, was enacted, to come into force on a day to be named by proclamation of the Lieutenant Governor. While the Report will continue to refer to the *Child Welfare Act*, reference will also be made to the *Child and Family Services Act, 1984*.

[3] See *supra*, ch. 3, sec. 8.

[4] With respect to how the best interests of a child are determined, see *Children's Law Reform Act*, R.S.O. 1980, c. 68, s. 24(2), enacted by S.O. 1982, c. 20, s. 1, in part.

Further, while courts may intervene to terminate parental rights, those rights arise spontaneously, generally — although, as we have seen, not universally — evidenced by birth registration.[5] The principle remains, then, that no special act of legal recognition is required to acknowledge the link between parents and children of natural reproduction. The legal link arises by the very fact of birth, and demands no act of public recognition to continue.

The above discussion of natural reproduction is not intended to illustrate the operation of a pure private ordering system. However, natural reproduction comes very close to such a system insofar as the decision to conceive a child is concerned. How would such an approach operate in the context of the new artificial conception technologies? A few salient examples should suffice to give the flavour of such a legal regime.

With respect to recourse to the new technologies, there might be no impediment placed on the right of any person to perform artificial insemination on herself or on anyone else. Performance of any required procedure would not have to be done by or under the supervision or direction of a physician. Moreover, unlike the case of adoption — which, as we shall see below, conforms to the state intervention approach — there would be no vetting of prospective participants in an artificial conception programme. "Suitability for parenthood" would be no more relevant in the artificial conception milieu than it generally is now in respect of natural reproduction.

Under a pure private ordering approach, prospective parents might be able to choose gamete donors at will, without having them screened beforehand. However, the absence of mandatory pre-screening would not remove the potential for civil liability where, for example, a donor negligently withheld, or a doctor negligently failed to discover, vital health information that, if known, would have precluded the use of the donor's gametes.

The private ordering model would conceivably permit a gamete donor to contract for the sale of sperm or ova on condition that he or she would bear no legal relation to any child resulting from the use of such gametes. Accordingly, no parental responsibilities, such as for support or maintenance, would ensue, and no rights of inheritance would arise from any relationship between the donor and the child.

Finally, artificially conceived children would be placed and named in accordance with private agreements. Mandatory birth registration requirements would be eschewed in favour of such agreements.

The private ordering model may conform to a spreading philosophy of non-regulation and deregulation of health care. Some have argued that public agencies have become more involved than is desirable in the regulation of how individuals meet their own perceptions of their needs, including the needs of family units.[6]

---

[5] See *supra*, ch. 3, sec. 5(a).

[6] Expressions of this view appear in Ontario, Ministry of Community and Social Services,

Influential advocates have come to urge minimal public paternalism and greater respect for individual choice.[7] They are critical of the degree of both public agency and judicial monitoring now undertaken of parental choices affecting children, where the state invokes its *parens patriae* power to supersede private parental ordering. It is urged by some that public limits to private initiative should be set only where harm to the vulnerable can be clearly shown. Children are vulnerable in this sense, but the argument for protection by preventing, for example, the means of their conception may seem to intervene in private choice at too general and abstract, and too personal, a level.

The relevance or desirability of the private ordering model as the appropriate model for artificial reproduction is perhaps reinforced by the fact that surgical repair of a woman's fallopian tubes is now undertaken at public expense without physicians or others asking whether she is married, is suited for motherhood or, for instance, has a history of child abuse. The belief that she ought to fall under special public scrutiny because she is seeking medical assistance to conceive a child does not appear to have been accepted in our society. Since I.V.F. offers, in effect, an artificial fallopian tube, recourse to this technology may be essentially no different than is recourse to reconstructive surgery; arguably, therefore, I.V.F. should remain within the sphere of private decision making.[8] The same argument respecting the appropriateness of the private ordering model could apply, for example, to the use of "fertility pills", where, again, no questions are asked concerning the recipient's "suitability for parenthood".

3. THE "STATE REGULATION" APPROACH

(a) GENERAL

As a conceptual matter, the *laissez-faire* private ordering approach that would respect and accommodate the intentions of individuals may be contrasted with what we have called the state regulation approach, where the law attempts to protect and further perceived public values and, to this end, limits individual choice. This is not to suggest, of course, that the state regulation approach is necessarily antithetical to the wishes of specific persons. Clearly, a law that makes manifest a particular social value may well conform completely to the philosophy of a particular individual and, therefore, may permit such a person to engage in the type of activity consistent with that philosophy. However, the state regulation approach does not begin with the premise that the wishes of individuals ought to be facilitated in all respects and that the law should serve this enabling function alone. Rather, it postulates a legal regime in which normative standards are declared at the outset, so that their conformity with private

---

The Children's Act: A Consultation Paper (1982) (hereinafter referred to as "Consultation Paper").

[7] See Goldstein *et al.*, *Before the Best Interests of the Child* (1979).

[8] See Dickens, "In Vitro Fertilization — Legal and Ethical Issues" (1984), 61 U. Toronto Med. J. 70, at 70-71.

expectations is, in one sense, purely fortuitous. On a conceptual plane, it may be said that the sanctity of perceived *public* values is favoured over the *private* wishes of individual members of society.

(b) ADOPTION LAW IN ONTARIO: A MODEL OF STATE REGULATION

The law of adoption[9] represents a clear illustration of the state regulation approach and, therefore, may serve as a model when determining the nature of any new legal regime dealing with artificial conception. For example, this model could well be most significant in the context of our proposals for reform respecting surrogate motherhood.

Adoption — the taking in of a stranger as a child of one's own family — has become almost the diametric reverse of the natural reproduction model. Adults can claim no right to adopt, although they may claim a right to be considered as potential adoptive parents upon grounds of equality with other applicants, measured by reference to the "best interests of the child" involved.[10] Moreover, with the current scarcity of infants available for adoption, the guidelines governing adoption have, in effect, become more rigorous. Standards of eligibility for adopting a child may, however, be different for hard-to-place children, such as physically or mentally handicapped, emotionally disturbed, ethnic minority, racially mixed, and older children.

But, by whatever measure standards may be set, the underlying principle is that an adult must be favourably assessed according to publicly defensible, but demanding, tests as a condition of eligibility to adopt a child. Further, adoption usually involves a children's aid society or the provincial Director of Child Welfare.[11] It is completed before a court, which confirms the adherence to normative standards, and which finally approves the permanent location of an

---

[9] See Part III of the *Child Welfare Act*, *supra*, note 2, and Part VII of the new *Child and Family Services Act, 1984*, *supra*, note 2.

[10] Section 76(b) of the *Child Welfare Act*, *supra*, note 2, provides that, before making an adoption order, the court must be satisfied that "the order will be in the best interests of the child". The definition of the phrase "best interests of the child" appears in s. 1(1)(b).

The new *Child and Family Services Act, 1984*, *supra*, note 2, provides in s. 1(a) that one of the purposes of the Act is, "as a paramount objective, to promote the best interests, protection and well-being of children". Section 130(2) sets out several matters that are to be taken into consideration where a person is directed in Part VII of the Act (relating to adoption) to make an order or determination in the best interests of a child. For some background to this portion of the new Act, see Consultation Paper, *supra*, note 6, at 141-42.

[11] But see s. 135(3) and (5) in the new *Child and Family Services Act, 1984*, *supra*, note 2:

> 135.-(3) No licensee except a licensee exempted under subsection (5) shall,
>
> (a) place a child with another person for adoption; or
>
> (b) take, send or attempt to take or send a child who is a resident of Ontario out of Ontario to be placed for adoption,

individual child in a particular home only after the child's interim placement there has proven satisfactory.

The adoption procedure in Ontario involves an initial assessment of applicants assessed according to criteria such as age, health, marital status and history, family structure and stability, employment status and, for instance, income level. These criteria have the effect of eliminating a number of applicants from further consideration. As we have seen, this may be problematic, since elimination on the basis of certain of the criteria applied at this stage may appear to be inconsistent with the *Canadian Charter of Rights and Freedoms*[12] and the Ontario *Human Rights Code, 1981.*[13]

Agencies responsible for child placement are strict, however, in seeking to locate children in the homes of adults coming as close as possible to the perceived ideal for an individual child. Thus, insofar as a newborn child is concerned, applicants in their mid- or late-twenties may reasonably be favoured over those of more advanced years, whereas older persons may be appropriate, for instance, for an emotionally disturbed teenage child. Arguably, this essentially is not so much discrimination against applicants on the ground of age, as selection of applicants in accordance with the child's best interests.

> without first notifying a Director of the proposed placement.
>
> . . .
>
> (5) A Director may designate a licensee that is an agency as exempt from the requirements of [subsection (3)].

[12] *Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, which is schedule B of the *Canada Act 1982*, c. 11 (U.K.). See *supra*, ch. 3, sec. 3(b).

[13] *Human Rights Code, 1981*, S.O. 1981, c. 53. Under the new *Child and Family Services Act, 1984, supra*, note 2, s. 140(4), an application for adoption may only be made by "one individual" or "jointly, by two individuals who are spouses of one another". The Explanatory Note accompanying the Bill (Bill 77) stated, in part, that "[s]ingle, divorced and widowed persons and couples who live together in a conjugal relationship are placed on the same footing, with respect to adoption, as married couples". Section 130(1)(d) of the new legislation provides that " 'spouse' has the same meaning as in Parts I and II of the *Human Rights Code, 1981*". Section 9(j) of the Code defines "spouse" to mean "the person to whom a person of the opposite sex is married or with whom the person is living in a conjugal relationship outside marriage".

By way of contrast, under the *Child Welfare Act* a court cannot make an adoption order in favour of an unmarried, widowed, or divorced person "unless the court is satisfied that there are special circumstances that justify the making of the order", and a joint application for adoption may be made only by a "husband and wife": *Child Welfare Act, supra*, note 2, s. 74(1)(b) and (4), respectively. Under neither piece of legislation may a joint application be made by a lesbian or homosexual couple.

With respect to applications by minors, both the *Child Welfare Act* and the *Child and Family Services Act, 1984*, preclude the court from making an adoption order in their favour unless there are "special circumstances" that justify the making of the order: *Child Welfare Act*, s. 74(1)(a), and *Child and Family Services Act, 1984*, s. 141.

Secondary screening consists in a homestudy[14] designed to anticipate the physical, material, emotional, and psychological environment into which a child might be placed.[15] This may include detailed scrutiny to make assessments of the applicants' personalities and distinctive characteristics, their motives in seeking a child to adopt, their personal tolerance and compatibility, and their social congeniality. Philosophical, religious, and, for example, educational and child-rearing convictions are taken into account, along perhaps with the applicants' own childhood experiences that may condition their expectations of behaviour and their acquired child-rearing models.

Such intimate scrutiny is not overtly designed to identify eliminating data, and some degree of unorthodoxy may not be accorded a negative weight. Nevertheless, in practice, screening tends to favour conformists over non-conformists. Those seeking to adopt children must yield personal privacy to the inspection and examination of social agencies and individual social workers, and must give an account of their reasons for seeking a child, in order that the necessary reports may be prepared.

After having considered the homestudy and other data,[16] the local children's aid society may approve the placement of the child with the prospective adoptive parents. This is not a final determination of the child's status, however, but simply authorizes the child's residence in the applicants' home for a probationary period, which, ordinarily, is of six months' duration.[17] An adoption order made by a court is dependent upon a favourable progress report on the child's adjustment in the home, and the necessary consents of the parents.[18] It is an offence to offer and to receive money for the giving of any consent for adoption.[19]

While most stranger adoptions are arranged by local children's aid societies, a substantial number are arranged privately. We now turn to consider private adoption, where considerable state involvement is also apparent.

Under Part IV of the pre-1978 *Child Welfare Act*,[20] there was limited state intervention in the case of a private adoption: only after a child was placed with prospective adoptive parents was there a requirement that the Director of Child Welfare be notified.[21] The local children's aid society was then requested to conduct a homestudy and submit a report to the Director regarding the desirability of granting an adoption order. Placing the child in the adoptive home prior to the homestudy effectively meant approval and subsequent legalization of the adoption, save for exceptional circumstances.

---

[14] See R.R.O. 1980, Reg. 96, s. 35, passed under the *Child Welfare Act*, *supra*, note 2. With respect to a homestudy, where a licensee under the new *Child and Family Services Act, 1984*, *supra*, note 2, is involved, see s. 136(1) of that Act.

[15] With respect to the homestudy, see *Child Welfare Act*, *supra*, note 2, s. 65(6).

[16] R.R.O. 1980, Reg. 96, s. 34. See *Child and Family Services Act, 1984*, *supra*, note 2, ss. 134 and 135.

[17] *Child Welfare Act*, *supra*, note 2, s. 75(1), and *Child and Family Services Act, 1984*, *supra*, note 2, s. 143(1).

[18] *Child Welfare Act*, *supra*, note 2, ss. 75(4) and 69, respectively, and *Child and Family Services Act, 1984*, *supra*, note 2, ss. 143(5) and 131, respectively.

[19] *Child Welfare Act*, *supra*, note 2, s. 67(1)(b), and *Child and Family Services Act, 1984*, *supra*, note 2, s. 159(b).

[20] R.S.O. 1970, c. 64.

The Child Welfare Act, 1978[22] changed this state of affairs dramatically. Under Part III of that Act,[23] there are two kinds of private adoption. First, there are those arranged by private adoption agencies, which are licensed organizations authorized to place children for adoption.[24] The second kind of private adoption is an adoption arranged by a person other than an adoption agency. While this form of private adoption was permitted under the pre-1978 Act, the subsequent *Child Welfare Act* imposes stringent controls, including a requirement of licensing,[25] to ensure that the placement and, ultimately, the adoption of the child, serve the child's best interests. These safeguards, it should be added, apply to the placement of children by private adoption agencies as well. Indeed, both licensed agencies and individuals are closely monitored by the state; for example, a licence may be subject to terms and conditions and may be revoked or not renewed for various reasons.

Private adoption agencies and persons licensed to place individual children for adoption must follow the same procedure. For example, before the placement of a child for adoption, an adoption agency or a licensed person, as the case may be, must submit a homestudy of the prospective adoptive parents to the Director of Child Welfare and obtain his approval.[26] Only in very few cases does the Act or the regulations distinguish between a children's aid society, on the one hand,

---

[21] *Ibid.*, s. 87.

[22] S.O. 1978, c. 85.

[23] See *Child Welfare Act, supra*, note 2.

[24] The licence, issued by the Director of Child Welfare — who is given considerable discretion respecting such issuance — is valid for one year (R.R.O. 1980, Reg. 96, s. 30(2)). There are 3 private adoption agencies in the Municipality of Metropolitan Toronto: Children's Resource and Consultation Centre; LDS Social Services (Church of the Latter Day Saints); and Adoption Agency and Consulting Services. There is also one in Windsor, the St. Clair Region Adoption Resource Centre. Under the pre-1978 Act, private adoption agencies did not exist.

With respect to licensing requirements under the new *Child and Family Services Act, 1984, supra*, note 2, see, generally, Part IX of that Act. Section 176(2) provides that "[n]o person other than a society shall place a child for adoption, except under the authority of a licence issued by a Director under this Part". Section 176(4)(b) states that "a licence to place a child for adoption shall only be issued to an individual or a non-profit agency".

[25] As with a private adoption agency, the decision to issue a licence, which is valid for one year, rests with the Director of Child Welfare (R.R.O. 1980, Reg. 96, s. 31(4)). See s. 178 of the new *Child and Family Services Act, 1984, supra*, note 2.

[26] In the case of an individual applying for a licence, the applicant must submit, among other things, the name and qualifications of a person proposed by the applicant to make

and a private adoption agency or a licensed person, on the other. In all cases, the courts, as well as provincial officials, seek to ensure that the best interests of the child are paramount.

It is apparent that, in contrast to natural reproduction, the adoption of children born to strangers is highly regulated, before the event, by public and judicial officers. The new relationship is legally recognized only after the completion of all formalities. The purpose of the regulation is to further the best interests of the children involved.

Given the demands made of prospective adoptive parents and the high level of state intrusion in their lives, some ineligible adults, and others who are clearly eligible but wish to preserve their privacy, may turn instead to artificial conception methods as a means of bringing children into their families. In assessing the applicability of the stranger adoption model when recourse is made to artificial conception, the critical question is whether there is a real distinction, from the public perspective and that of the child, between adoption and artificial conception. With respect, for example, to the critical issue of screening prospective parents, is it meaningful to differentiate between adoption, which involves children in search of families, and artificial conception, which involves families seeking children? Is this distinction relevant when considering the well-being of the child in a particular family?

While the state intervenes extensively in the case of adoption by strangers, the treatment of prospective adoptive parents is far less rigorous in the case of "step-parent adoption".[27] A partner in a marriage may wish to adopt a child of his or her spouse, whether that child was born before marriage, in an earlier marriage of the spouse, or during the present marriage but conceived outside it. The welfare of the child may favour legal regularization of its status *vis-à-vis* the natural parent's spouse where the child will have a close continuing relationship with that person and will consider him or her a *de facto* parent. What has been

---

the homestudy of the prospective adoptive parents (R.R.O. 1980, Reg. 96, s. 31(2)(b)). A list of persons qualified to do the homestudy is maintained by the Adoption Unit, Operational Support Branch, in the Ministry of Community and Social Services. Where a licence is issued, it will designate a person to conduct the homestudy. Under the new *Child and Family Services Act, 1984*, *supra*, note 2, see ss. 136 and 135(3).

[27] The legal procedures applicable regarding step-parents apply also to certain other relatives of a child: see *Child Welfare Act*, *supra*, note 2, s. 59(1)(c). With respect to "family adoption" under the *Child and Family Services Act, 1984*, *supra*, note 2, see s. 140(2):

> 140.-(2) The court may make an order for the adoption of a child, in the child's best interests, on the application of,
>
> (a) a relative of the child;
>
> (b) the child's parent; or
>
> (c) the spouse of the child's parent.

The terms "relative" and "spouse" are defined in s. 130(1)(c) and (d), respectively.

called psychological parenthood[28] has received a wide measure of legal recognition. For example, support duties may be imposed upon adults who treat children as being children of their families.[29]

Like stranger adoptions, step-parent adoptions must be approved by the court.[30] However, an important difference exists in that, while in the case of a stranger adoption, the court determines the future home and social parentage of the child involved, this is not so in the case of a step-parent adoption. A child who is the subject of a step-parent adoption ordinarily will remain in the charge of his or her natural parent and of that parent's spouse, and will remain in their home whether or not the court makes an adoption order. The step-parent adoption in such a case does not constitute the new family, but simply recognizes *de jure* a relationship that has come into being *de facto* and that the parties intend will endure. Accordingly, the judicial function is less to screen than to monitor and to regularize status.[31]

The practice in step-parent adoptions is for the courts not to require that a report be submitted on the adjustment of the child in the home, nor to impose a probationary period before making an adoption order.[32] From the point of view of the child's welfare, little purpose would be served in withholding approval, unless the child were living in an obviously dangerous or unhealthy setting, in which case the child might well be removable from control of the natural parent under child protection legislation.[33] While those seeking adoption of strangers must show themselves suitable, prospective step-parents have to be shown to be demonstrably unsuitable to become legal parents of their spouses' children.

The step-parent adoption model has more than a theoretical relationship to methods of artificial conception. A.I.D., I.V.F. involving one donor gamete, and surrogate motherhood all involve or may involve the birth of a child to a natural parent who is a partner in a marriage. In order to regularize the relationship between the child and the spouse not genetically related to the child, step-parent adoption is necessary by that spouse. To the extent that step-parent adoption offers an easier means of regularizing an existing social relationship, without, however, precluding a court from monitoring the situation, it illustrates a type of compromise approach in perhaps analogous artificial conception contexts.

---

[28] See Goldstein *et al.*, *supra*, note 7.

[29] See, for example, *Family Law Reform Act*, R.S.O. 1980, c. 152, s. 16. See, also, *ibid.*, s. 1(a) (which defines the word "child").

[30] *Child Welfare Act*, *supra*, note 2, ss. 70 *et seq.*, and *Child and Family Services Act, 1984*, *supra*, note 2, s. 140(2).

[31] However, the court does have a discretion to require a report on the adjustment of the child in the home under the *Child Welfare Act*, *supra*, note 2, s. 75(5), and with respect to the 6 month probationary period. See *Child and Family Services Act, 1984*, *supra*, note 2, s. 143(6).

[32] But see *supra*, note 31.

[33] See Part II of the *Child Welfare Act*, *supra*, note 2, and Part III of the *Child and Family Services Act, 1984*, *supra*, note 2.

Admittedly, the step-parent adoption model seeks to regularize an *existing* relationship with an *existing* child, whereas, in the case of artificial conception, no child is yet in existence. Again, however, we must ask the question whether this difference should induce us to create a different, perhaps more rigorous regime in the case of artificial conception where one donor gamete is used. Should we eschew the step-parent adoption approach — which ordinarily exhibits little, if any, pre-screening — where the artificially conceived child would be biologically connected to one of the marriage partners?

4. THE PRESENT ONTARIO "APPROACH": A DISAVOWAL OF EXTREMES

Our examination of the present law and practice relating to artificial conception, as well as a consideration of the wider context of family law and the law relating to children, permits us to offer a few observations concerning the present Ontario "approach" to matters relevant to this Report. To put it succinctly, existing law and practice — relating to such matters as the decision to bear a child, medical care respecting the birth and treatment of the child, and the raising of the child (including child protection laws) — reveal what we may loosely call a hybrid approach, a disavowal of extremes, where different responses are offered with respect to different areas of concern. Looking at the law as a whole, as opposed to individual facets of it, it may be said that neither the state regulation approach nor the private ordering approach, in its pure form, holds absolute sway.

Having regard to the broader, family law context, we see the manifestation of state regulation in such statutes as the *Divorce Act*[34] and the *Family Law Reform Act*,[35] both reflecting normative standards held by the community at large. More specifically in the case of children, Acts such as the *Children's Law Reform Act*[36] and the *Child Welfare Act*[37] indicate society's abiding concern to protect children and further their welfare. The court's traditional *parens patriae* jurisdiction, child protection laws, and the court's authority to deal with custody matters, are critical components of our legal and social system. And, as we have seen, so too is the law relating to adoption, where the state intervenes at the outset to ensure, as much as possible, that adopted children will be placed in an hospitable, healthy environment.

On the other hand, however, the law leaves unregulated or partially regulated a substantial portion of family-related matters. The most obvious area of private ordering occurs in the case of introducing a child into a family by natural reproduction, an area that the state virtually ignores. And while the state may intervene where, for example, a young child is not in school or is in need of protection, the raising of children is left mainly to the parents. In addition, the matter of custody generally may be determined by the parents themselves, although their decisions are always subject to review by the court.

---

[34] R.S.C. 1970, c. D-8.

[35] *Supra*, note 29.

[36] *Supra*, note 4.

[37] *Supra*, note 2. See, now, *Child and Family Services Act, 1984*, *supra*, note 2.

In the case of artificial conception, the half-world of a largely unregulated and unrecognized legal status is manifest. Matters such as the status of the artificially conceived child and birth registration are, in one sense, regulated by the present law, but the law does so only by indirection. However, the parties' intentions do, in fact, tend to prevail, at least in respect of A.I.D. and I.V.F. where a donor gamete is used: in the vast majority of cases, the mother and her husband are registered and act as the child's parents, and the donor preserves his anonymity forever.

The present legal regime, then, even in the context of artificial conception, may in one sense be characterized as a mix of unconscious or indirect state regulation and private ordering, although, to meet the wishes of the parties in many cases, there must be reliance on legal presumptions fashioned for different times and purposes, rather than on the truth.

However, as we have said before, the present regime, whatever its "approach", does not deal with artificial conception in a satisfactory manner. Accordingly, we must fashion new tools, animated by a desire to serve the best interests of the child, the parties, and society.

5. CONCLUSIONS RESPECTING THE GENERAL APPROACH TO REFORM

In chapter 3 of this Report, the Commission came to the conclusion that the law must take special cognizance of the new artificial conception technologies. In the present chapter, we have examined two main conceptual approaches to law reform in this area, the state regulation approach and the private ordering approach.

When attempting to assess which of the two approaches ought to be adopted in the case of artificial reproduction — or, indeed, whether some hybrid approach is preferable — the models of natural reproduction and adoption immediately spring to mind. More specifically, we inevitably come face to face with a general, fundamental question: should the law treat artificial reproduction differently than the manner in which it treats natural reproduction, at least insofar as the decision to conceive a child is concerned? If the private ordering approach is eschewed in favour of the state regulation approach in the case of artificial reproduction, on what basis is such a determination to be made?

We turn first, then, to consider these basic issues respecting the general direction of the new legal regime governing artificial conception. Subsequent to this examination, we shall discuss the issue whether all the new technologies, or all aspects of each technology, ought to be treated in the same fashion, or whether some other approach is necessary or desirable.

When considering the legal regime that ought to apply in the case of artificial conception, we start with the basic, governing proposition that there should be no intervention, in any form, unless the public interest is likely to be threatened or frustrated by the absence of some form or degree of regulation. Indeed, this formulation of the role of the state and its many organs applies generally to all facets of human endeavour: our traditions require that a reasonable justification must be found for legislative or other intervention.

From our examination of the legal, moral, ethical, social, and psychological implications of artificial conception, and from the submissions of interested persons and groups and the meetings with our multidisciplinary Advisory Board for this project, the Commission recognizes clearly that there is no community consensus on several of the fundamental issues raised in this Report. Not surprisingly, this conclusion applies to the critical question whether artificial conception ought to be treated differently from natural reproduction and, if so, in what circumstances and why.

As we indicated earlier, one cannot necessarily arrive at an answer to these questions exclusively by the strict application of the principles of logic or deductive reasoning. Human relations — particularly in so sensitive and personal an area as human reproduction and the nature of family life — are governed by a diversity of factors: for example, the limits of tolerance of the community, determined in part by rational and nonrational fears, the conscience of individual members of society, and the financial and other practicalities of state intervention.

The Commission acknowledges that there is a profound lack of agreement in the community on certain basic issues involving artificial conception. Moreover, given the relative novelty of most of the technologies and the rapidity of scientific advances, community attitudes have been fluctuating to a significant degree. Not surprisingly, these controversies and diverse and varying opinions have been reflected in the views expressed by individual members of the Commission.

However, while no one can legitimately assume to speak for all segments of the community on so controversial a topic as artificial reproduction, the Commission can attempt to give serious consideration to the conflicting views presented to us directly or gleaned from the increasingly voluminous literature. Our proposals for reform, then, are based on our perception of prevailing community standards, however amorphous they may appear to be, and our view of what members of the community appear to want or be willing to tolerate. Without slavishly and uncritically adopting such standards, they do serve to indicate how members of society believe we ought to be governed. We cannot simply ignore prevailing views, in a sense placing ourselves above the community, enlightening it concerning the "best" ordering of society. In the area of human conception, whether natural or artificial, it would be presumptious to take such licence.

Having regard to the considerations just described, we have come to the conclusion that the law must impose a degree of intervention in the case of artificial conception that is neither desirable nor possible in the case of natural reproduction. The wishes of the parties — particularly, the desire of the prospective social parents to have a child — are, in fact, only one of many considerations that should affect the determination of the nature of the new legal regime. Given the implications of artificial conception for persons other than the prospective parents, we strongly believe that "private ordering" cannot be the sole governing factor. In our view, there are sound philosophical and practical reasons for embracing, at least in some areas, an approach that does not give free rein to the wishes of the parties.

First and, we believe, foremost, we wish to emphasize our concern for children conceived by means of the new reproductive technologies. Modern society has been particularly solicitous of the welfare of children. Their vulnerability is obvious and, therefore, their protection must be a priority.

The view that the interests of children should be paramount is reinforced by the very Terms of Reference of this Report. In his Letter of Reference to the Commission, the Attorney General specifically asked us to consider, *inter alia*, the "legal status and legal rights of the child and the safeguards for protecting the best interests of the child". But it is clear that all the enumerated matters to which our attention was expressly directed bear on the welfare of artificially conceived children. And, finally, at the close of his Letter of Reference, the Attorney General stressed, yet again, the "deep importance" of the enumerated issues for all persons involved, "particularly the children".

We have a clear mandate, therefore, to fashion our proposals for reform having regard to what we strongly believe ought to be our primary consideration — the best interests of the child. In so doing, we have come to the conclusion that artificially conceived children would not be well served by a pure private ordering approach — an approach that would permit any person to make use of the new reproductive technologies, with the unfettered right to choose gamete donors, and with no other safeguards to ensure adequate prenatal medical protection and, as much as possible, that the future child will be raised in an hospitable and healthy environment.

Some persons cannot fully understand or cope with the unique problems of bearing and raising an artificially conceived child, particularly where donor gametes are used. The pre-conception period, which may involve frequent failures to conceive, both naturally and by artificial means, may be exceedingly frustrating, even traumatic. Some may be unable to relate, in a satisfactory way, to a child to whom he or she has no biological connection. Others may use the fact of artificial conception as a sword against the spouse or child in a moment of extreme tension or hostility. The existence of an artificially conceived child may, in some cases, prejudicially affect the marriage. Feelings of guilt or inadequacy may arise and may be difficult to overcome.[38]

---

[38] See, generally, Czyba and Chevret, "Psychological Reactions of Couples to Artificial Insemination with Donor Sperm" (1979), 24 Int. J. Fertil. 240; Berger, "Psychological Aspects of Donor Insemination" (1982), 12 Int. J. Psychiatry in Med. 49; Watters and Sousa-Poza, "Psychiatric Aspects of Artificial Insemination (Donor)" (1966), 95 Can. Med. Ass'n J. 106; Levie, "An Inquiry into the Psychological Effects on Parents of

For these and other reasons, psychological testing and, certainly, counselling are often suggested or required by practitioners before the recipients, or their spouses or partners, undergo treatment. Doctors show great concern respecting the likely ability of the interested parties to deal with the fact of artificial conception. For any unsuitability in this regard will potentially do more than shatter the stability of a marriage: it may well have a profound, adverse effect on the resulting child.

Finally, we wish to stress that the reasons advanced above for endorsing a type of state regulation approach in the area of artificial conception are founded ultimately on a wider, community interest. Society clearly has an interest in protecting its constituent members — and particularly those, such as children, who can least protect themselves — for, in so doing, it essentially ensures its own well-being. We believe that artificial reproduction has a unique, public dimension that necessitates the kind of state intervention that we recommend in this Report.

We now turn to consider a matter that is related to, yet distinct from, the more fundamental issue discussed above. In previous portions of this chapter, we set forth two basic conceptual approaches to law reform, that is, the state regulation approach and the private ordering approach. We concluded that some kind of state regulation approach is required in respect of the law governing the use of the new reproductive technologies. A question that now arises is whether all the technologies, or all aspects of their use, ought to be governed by precisely the same set of rules. For the sake of consistency, it may appear appropriate that the same general approach ought to be adopted for all means of artificial reproduction. One may assume, for example, that the legal, moral, and other issues pertaining to A.I.D. are much the same as those issues in the context of I.V.F.

As a general proposition, there is, in fact, a substantial similarity between these two means of artificial conception. And, therefore, to a great degree, the Commission does favour treating the two technologies in the same manner. We do so, however, not essentially because, for philosophical or other reasons, we first have adopted a particular conceptual approach to reform. Indeed, we do not believe that the internal cohesion of our proposals or the dictates of public policy necessarily mandates strict adherence in all cases to the state regulation model for reform, to the exclusion of some variant of the private ordering model.

Rather, we choose to adopt a more pragmatic, functional approach, deciding on the requirements of each situation on its own, individually assessed merits, having regard to all the circumstances of the particular case. Accordingly, the special features of one type of artificial conception technology might lead to a proposal that would involve some state regulation, while another might require an essentially "hands-off" approach. The generally similar treatment of

---

Artificial Insemination with Donor Semen" (1967), 59 Eugen. Rev. 97; and Annas, "Fathers Anonymous: Beyond the Best Interests of the Sperm Donor" (1980), 14 Family L.Q. 3.

A.I.D. and I.V.F. arises, then, from the simple fact that the issues these technologies raise are, in the main, very much the same.

But, as we shall see, we do not believe that the same holds true for surrogate motherhood, notwithstanding the fact that surrogate motherhood involves either artificial insemination or I.V.F. The justification for some type of interventionist approach respecting many aspects of artificial conception — particularly the selection of recipients and their spouses or partners, if any — is even clearer, we believe, in the case of surrogate motherhood. A foremost consideration, again, is the possibility of emotional harm to the child should he or she, for example, be rejected by the social mother, either because she cannot cope with the situation or because of some intra-family dispute.

But the possibility of emotional harm in the surrogate motherhood context extends beyond the resulting child and the child's social parents. The fact that a surrogate mother has obligated herself to give up her child to strangers may vitally affect her, not only at the child's birth, but also throughout her pregnancy. Any instability or emotional scarring may then be transferred to other persons with whom she has contact, particularly her husband or partner and her children. Indeed, the children of a surrogate mother, especially if they are young, may well become emotionally disturbed by the thought that their mother has chosen to give up her child.

Another possible reason for more rigorous state intervention in the selection of surrogate mothers and social parents concerns the possible reaction of an unstable mother or parents to the birth of a handicapped or impaired child. The birth of such a child may induce the intended social parents to abandon their plans for taking custody, and the surrogate mother may feel no greater desire to keep the child. Even where the child is taken in by one of the parties, a sense of betrayal or guilt may adversely affect the relationship with the child. Some process of selection may serve to reduce the chances of a physical or psychological abandonment of the child.

Yet another possible rationale for intervening in the case of surrogate motherhood also relates to the selection of surrogate mothers. Here we are referring to the possibility that the unregulated selection of surrogate mothers may lead to the exploitation of these individuals. For example, impecunious or otherwise vulnerable women may be induced to participate as surrogate mothers, either for the money promised to them or because, for some other reason, they are unable to reject the blandishments of persons coordinating the arrangement.

The justifications, described above, for some form of intervention in the artificial conception process are not exhaustive. However, they do offer illustrations of what may be called the public interest — an interest that, in the main, welcomes medical advances in the treatment of infertility, but rejects the notion of private ordering for some intermediate position.

6. ANCILLARY ISSUES

Having concluded that, under certain circumstances, the state ought to intervene in respect of artificial conception in the interest of broader societal values, several subsidiary, but no less critical, questions arise. For example, to what extent and in respect of what activities, if any, should such intervention take the form of either outright prohibition or regulation? If regulation is desirable in respect of any or all of the activities in question, how should the guiding norms be set, and who should set and apply them?

(a) PROHIBITION OR REGULATION?

We turn first to consider the two forms by which limits may be placed on an individual's private activities, namely, prohibition and regulation. It should first be made clear that the law need not necessarily adopt only one of these two interventionist means. While clearly a wholesale prohibition respecting the use of artificial conception services would leave nothing to regulate, it is entirely reasonable to envisage a legal regime in which some aspects of the new technologies are prohibited, some are strictly controlled, and some are the subject of minimal regulation.[39]

For example, one might wish to prohibit minors from donating ova for use in I.V.F. programmes because extraction of ova may involve surgical intrusion and because a woman's complement of ova is finite. One might believe it essential to prohibit all forms of what may be termed "genetic engineering", but countenance research at approved or licensed research centres that have ethical review committees to oversee such activities. Or some latitude might be tolerated in respect of payment to semen donors of their reasonable expenses.

The list of possible permutations and combinations involving prohibition and regulation could easily be expanded. But the essential point is that our perception of the different facets of the subject matter should not be static or rigid; we must be open to the suggestion that a hybrid regime, in which a spectrum of responses, from total prohibition to slight regulation, may be both desirable and possible.

The determination of where specific activities ought to be placed on this spectrum — and not left to the unfettered discretion of individuals — is influenced by several more or less obvious factors. As we indicated in the Introduction to this chapter, matters of logic almost inevitably mix with basic human fears and emotions to produce in each of us a sense of what we may be willing or able to tolerate. The spectre of cloning or experimental genetic manipulation may well be anathema to almost everyone in the community, so that a doctrinaire stance — outright prohibition — may be palatable. But, in other areas, consensus may be difficult, even impossible, to achieve. For example, there has been a continuing debate concerning whether adopted children ought to be entitled to have access to information respecting their natural parents, a debate that arises as well in the context of artificial conception where "anonymous" donor gametes are used. Rational reasons favouring disclosure vie with concerns respecting the possible emotional reactions of the various parties. And so, insofar as adoption law in Ontario is concerned, we have moved slowly away from an extreme posture of secrecy to a regulated access regime.[40]

---

[39] It bears mentioning here that the criminal law power in Canada is vested in the federal Parliament: see *Constitution Act, 1867*, 30-31 Vic., c. 3 (U.K.), s. 91.27. However, the provinces may impose a fine, penalty, or imprisonment to enforce any valid provincial law: see *ibid.*, s. 92.15. Provincial penalties attach, for example, to the offering and accepting of money for parental consent to the adoption of a child: see *Child Welfare Act*, *supra*, note 2, s. 67, and *Child and Family Services Act, 1984*, *supra*, note 2, s. 159. See, also, *supra*, ch. 3, sec. 8(b). They also attach to the selling of human body products, except blood and blood constituents, for therapeutic, educational or research purposes: see *Human Tissue Gift Act*, R.S.O. 1980, c. 210, ss. 10 and 12. See, also, *supra*, ch. 3, sec. 4(a). The operations of private adoption agencies and children's aid societies fall under degrees of penal scrutiny, even though judicial approval is a precondition to the adoption of individual children: see *supra*, this ch., sec. 3(b).

Aside from assessing the necessity for, or desirability of, either prohibition or some type of regulation based on the particular attributes of each activity, it must be borne in mind that complete prohibition or strict regulation, however justifiable in the abstract, may produce evasion, especially by the desperate or more affluent, who may seek to obtain services in more accommodating jurisdictions. And such violation of the law may well be seen as legitimate in the eyes of the majority or a substantial minority of the population.

But the danger of evasion as such is not the only problem respecting strict punitive measures directed at certain activities. For example, given the relative simplicity of the artificial insemination procedure, its prohibition or strict control may encourage laypersons to perform the insemination on themselves and others, without medical supervision.[41] In other words, this type of artificial reproduction may be driven underground, away from physicians who have the requisite skills and knowledge to prevent or remedy any medical complications that may arise in the recipient or child.

---

[40] See *Child Welfare Act*, *supra*, note 2, s. 81, and *Child and Family Services Act, 1984*, *supra*, note 2, s. 158, respecting the voluntary disclosure register. But see *ibid.*, s. 157(1):

> 157.-(1) Despite the provision of any other Act, no person shall inspect, remove, alter or permit the inspection, removal or alteration of information that relates to an adoption and is kept,
>
> (a) by the Ministry;
>
> (b) by a society or licensee; or
>
> (c) in the register maintained under section 158,
>
> or disclose or permit the disclosure of such information that the person obtained from the records of the Ministry, the records of a society or licensee, or the register maintained under section 158.

Section 157(2) provides for exceptions to the prohibitions in subsection (1).

See, generally, O'Donnell, "The Four-Sided Triangle: A Comparative Study of the Confidentiality of Adoption Records" (1983), 21 U.W.O.L. Rev. 129.

[41] See *supra*, ch. 2, and *supra*, ch. 3, sec. 2.

In the case of surrogate motherhood, it is clear that key medical, legal, and other services are available — and have been delivered, to our knowledge, on at least one occasion — outside Ontario to Ontario residents, largely because of the perceived, and correct, view that surrogate motherhood agreements are not enforceable in this Province. Again, attempted suppression does not necessarily result in the elimination of the activity, but may create more perils than anticipated. Indeed, one of the dangers of any prohibition of artificial conception is that it may prejudicially affect children conceived in this fashion. We have already seen that the present law deals only inadvertently with such critical issues as the legal status of an artificially conceived child.[42]

There are, then, important human and other costs of prohibition that must be weighed in the balance before seeking to render a particular practice illegal, even though it may be deemed not to be worthy of any active protection. As in the case of our choice between state regulation and private ordering as a general approach to law reform in this area, these factors have led us to the conclusion that a hybrid regime is both necessary and desirable. Such a regime most adequately reflects the complexity of the subject and the differing norms that, we believe, ought to govern different aspects of each of the new technologies.

(b) THE INSTRUMENTS OF REGULATION

Assuming the adoption of a regulatory approach, at least for some purposes, a second set of issues concerns the particular instruments of regulation. Who should set the requisite standards, how should they be set, and who should apply them? Again, there are several alternative approaches to the resolution of these questions.

The establishment of norms governing conduct may be left to the Legislature, by means of legislation, to the courts, through the development of common law principles, to governmental or other tribunals, to professional bodies, such as the College of Physicians and Surgeons of Ontario, or to a combination of such institutions. In some cases, a statute or regulation may set a standard to be applied by the medical profession itself. In other cases, legislation may be monitored and interpreted by an administrative body or by the courts. Again, there is no universal rule; the particular combination selected in respect of the establishment and application of normative guides depends on several factors, including the type of the particular activity in question and the nature and extent of the control sought.

Regulation need not, of course, take the form of formal, written norms emanating from some body specifically charged with developing applicable guidelines, for example, the Legislature or even the College of Physicians and Surgeons of Ontario (by means of rules of professional conduct). Regulation of conduct may take place incrementally, through the medium of the courts. The courts, utilizing existing common law or developing new rules, may either interpret or add glosses on legislation or written guidelines from some other source, or may deal with controversial issues in respect of which there is no universal social policy or consensus and, hence, no "legislated" philosophy.

---

[42] See *supra*, ch. 3, sec. 5.

Courts may, for example, exercise a valuable role in determining such issues as the standard of care that is to be applied by practitioners of artificial conception, and whether institutions such as clinics and hospitals, through their infertility units, bear responsibility for their practitioners' negligence. The advantage of leaving such matters to judicial development is that such development will occur within a generalized jurisprudence, and not be, without justification, distinctive or anomalous to artificial conception.

Further, regarding the establishment of the requisite standard of care, court decisions in some cases may reflect developments in the state of the reproductive art as they occur, unfettered by a legislated or regulated framework that may become based upon outmoded techniques or discredited practices. This may be particularly important, since artificial conception technologies are still evolving and many variations in clinical practice exist, the relative advantages of which have yet to be determined by properly conducted studies. A legislated scheme that embodies any particular practice may give undue preference to a procedure that proves to be no better than others and possibly worse, and may inhibit development of superior alternatives. Courts may well compel the raising of standards by finding that the existing practice — for example, on screening gamete donors for adverse genetic traits or venereal infection — does not satisfy legal requirements respecting the standard of care.

It has been observed that "[t]he most ethically and politically controversial aspect of I.V.F. is the status of the embryo".[43] A legislated solution to this controversy would be of far-reaching effect, and would have implications for many areas of the law. A judicial approach would define the fact situations in which a particular judicial decision is to apply, and the purposes for which a given solution is designed. Judicial explanation, which itself may undergo several reinterpretations, may be preferable to the structured and traditional language of legislation to say within what limits a particular resolution is to operate.

However, a difficulty with entrusting matters to the courts is that, in some cases, they may adhere to precedents that are not related to advances in artificial conception technologies. Judgments may continue to embody public policy perceptions conditioned by the supposition that conception results only from sexual intercourse, or, perhaps at some future time, that artificial conception results only from artificial insemination or I.V.F., or a particular mode of artificial conception. The early disposition to equate A.I.D. with adultery[44] shows how judicial attitudes, while perhaps understandable in one era, may become and remain part of the problem in another era, which legislation may be required to resolve. Courts may take strict and limiting views, for instance, regarding the inheritance rights of a child not genealogically related to a testator, such as the parent of a husband whose wife had the child by A.I.D., when the testator made a bequest to the husband and the "heirs of his body".

---

[43] Annas and Elias, "*In Vitro* Fertilization and Embryo Transfer: Medicolegal Aspects of a New Technique to Create a Family" (1983), 17 Family L. Q. 199, at 208.

[44] See *Orford v. Orford* (1921), 49 O.L.R. 15, 58 D.L.R. 251 (H.C.J.). In the United States, see *Doornbos v. Doornbos*, 139 N.E. 2d 844 (Ill. App. 1956), and *Hock v. Hock*, unreported (Cir. Ct. Cook Co. Ill. 1945).

There is, however, a dynamic interaction between legislation and judicial attitudes, since courts tend to note the thrust of legislative initiatives, and often take leads from them. If legislation were enacted specifically to accommodate all or certain types of artificial conception, for instance, it might be unlikely that the courts would regard agreements made in furtherance of such particular conceptions as void as against public policy. Courts may, of course, decline to admit a new kind of claim, on the ground that the matter raises a significant issue of public policy that should be tackled by the Legislature before a solution is incorporated into the law by the courts; and they may similarly feel that private arrangements regarding sensitive areas, such as surrogate motherhood agreements, should be approved by an Act of the Legislature rather than by a court. Once generally accommodating legislation has been passed, however, the courts may find such legislation to be an expression of public acceptance or tolerance in which they may find inspiration and direction.

It is never certain, on the other hand, that courts will follow the lead of legislation, or interpret, apply, or extend its provisions in a collaborative way. Judges may hesitate to go further than recent legislation, reasoning that, had the Legislature intended its scheme to embrace an additional step, it would have so provided, and that its failure so to provide is evidence of a contrary intention. For avoidance of doubt, legislation may have to be drafted comprehensively in order to address foreseeable areas of possible application. Oversights and issues beyond anticipation may then have to be left to the courts, but the legislative design may, in principle, aim to be all-embracing, as a self-contained and definitive code.

Alternatively, it may not be necessary to resolve every detail in order to achieve legislation that is sufficiently comprehensive to address a given issue. Depending on the particular issue, minimal legislation may be enacted, fashioning the critical skeleton of a new policy, but leaving the developed form to be supplied by an emerging jurisprudence. Legislation also may properly be structured in order to anticipate and accommodate further developments in related case law, without seeking to affect its direction. If the case law fails to develop, or follows an unsatisfactory direction, the Legislature always retains its residual power to supplement or supersede judgments.[45]

---

[45] The procedural difficulty with reliance upon the courts to flesh out a legislated scheme is that persons detrimentally affected by the law may lack the financial means to seek redress in the courts; or after having served the public interest in achieving clarification of the legislation by means of litigation, they may lose and become burdened, personally, with costs. A related difficulty is that individuals or interest groups may not have *locus standi* to take their complaints to court.

In the end, while motivated individuals and groups will continue to pursue legal rights in the courts, despite recognized obstacles, others may believe that they have more

In the same way that certain matters may be left to be resolved by the courts, other matters may best be resolved according to medical professional ethics, bearing in mind that the practice of medicine may include artificial conception and, accordingly, that such a practice may be undertaken only by doctors or persons under their supervision or direction.[46]

We have seen that the Legislature has granted the College of Physicians and Surgeons of Ontario wide powers of self-government. Among other things, the College may regulate the practice of medicine and establish standards of knowledge, skill, qualification, and practice among members.[47] In addition, the College may set ethical standards for doctors.[48]

Having regard to the fact that the statutory mandate of the College is exercised "in order that the public interest may be served and protected",[49] it is not surprising that persons who are authorized to practice medicine by the College are subject to compulsory discipline for professional misconduct. "Professional misconduct" is defined in regulations made under the *Health Disciplines Act*,[50] primarily in collaboration with the provincial Ministry of Health. The list of activities constituting professional misconduct tends to be specific, but a residual category exists for "conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional".[51]

The College of Physicians and Surgeons of Ontario conscientiously consults with those whom it regulates and with the wider community beyond, in the process of formulating its ethical position on various matters, and it is open to public and media comment and ministerial influence. It may strike committees to address particular issues and may involve non-professionals in its deliberations and recommendations. Accordingly, it may reflect an ethical consensus with considerable credibility, although it may be expected that the opinions of the professionals it regulates, who are also strongly represented on the governing council, will be heard with special clarity.

The College periodically updates its principles of ethical practice, and contributes to public education and discussion concerning such principles. It attempts to respond to past events and to anticipate future possibilities, so that practitioners generally are offered guidance when they contemplate innovative

---

effective access to the democratic legislative process than to the judicial process, and look to legislation to solve their problems.

[46] See *supra*, ch. 3, sec. 2.

[47] See, for example, *Health Disciplines Act*, R.S.O. 1980, c. 196, s. 46(2) (reproduced *supra*, ch. 3, note 9), and s. 50.

[48] See *Health Disciplines Act*, *supra*, note 47, ss. 46(2)(d) and 51(1)(k).

[49] *Ibid.*, s. 46(2).

[50] *Supra*, note 47.

[51] R.R.O. 1980, Reg. 448, s. 27(32). See, generally, *supra*, ch. 3, sec. 3(d).

practices.[52] Further, unlike courts of law, the College will accommodate requests from doctors for *ad hoc* ethical rulings based upon hypotheses and anticipated scenarios. Its familiarity with the realities of practice and its access to scientific and technical data may afford its judgments a conviction that more abstract theorizing may lack.

Contributions to the debate on the ethics of professional practice may come through initiatives of many organizations other than the provincial College. The views of responsible bodies, such as the Medical Research Council, may be of significance regarding, for example, research concerning the use of gametes and embryos. Moreover, the reports of governmental agencies or professional bodies in Canada and around the world[53] can be expected to be seriously considered. Professional ethical principles may, therefore, be informed by a variety of national and international considerations that may influence perceptions of what provincial ethical practice requires. Inasmuch as the ethical assessments of the College of Physicians and Surgeons of Ontario may draw from the same body of knowledge that would be relevant to the design of statutes or regulations, such assessments may serve equally to control conduct within the medical profession, and may even enjoy the greater confidence and sympathetic compliance of individual physicians.

Accordingly, it is possible to leave some matters unaddressed by statute, to be determined by authorized practitioners acting under professional guidance. Practitioners are accountable both through the courts, for the injuries they wrongfully cause to individuals they have a legal duty to protect, and through their professional disciplinary councils, for breach of ethical rules, professional misconduct, or falling below the established standards of their profession. Further, while legislation may be introduced to govern such activities as research, it may be equally appropriate, and perhaps preferable, to confine sensitive research, such as research on embryos, to special centres that maintain credible ethical screening of research proposals through institutional review boards, and that undertake departmental and other monitoring of clinical and research practices.

An advantage of this approach to the control of individual medical practice is that it would utilize existing personnel, institutions, and established mechanisms, whereas new regulatory legislation might require a policing and enforcement service that might be less than comprehensive, costly, and poorly received among professionals conscious of their responsibilities. By the same token, some may argue that professionals are generally too socially conservative, health professionals in particular having been suspected of undue paternalism in pursuing patients' perceived interests rather than patients' expressed wishes. These and other advantages and disadvantages that attach to the control of artificial conception through medical and related professional guidelines must be balanced against the advantages and disadvantages of seeking control through express legislation.

---

[52] Although it does bear noting again that special guidelines respecting artificial conception have yet to be promulgated by the College in Ontario, The Society of Obstetricians and Gynaecologists of Canada has published a "Statement on In-Vitro Fertilization and Embryo-Transfer", in the Bulletin of the Society, Vol. VI, No. 3, May/June, 1984.

[53] See *infra.*, ch. 5, and the Appendix to this Report.

In light of the Commission's philosophy and previous conclusions respecting the appropriate approach to law reform in the case of the new reproductive technologies and respecting the nature of the limits that should be placed on an individual's private actions, it should come as no surprise that, in the present context, we once again eschew a dogmatic approach that would require uniform treatment to be provided in all cases. We believe that some matters — clearly those that involve outright prohibition of certain activities — necessitate statutory control. Other matters, setting out procedural details or licensure requirements, may be left to the regulations. And yet further matters, involving essentially medical judgment or involving ethical issues relating to the conduct of physicians, may be determined by the medical profession, either formally or informally. In all, or most, of these cases, recourse may well be had to the courts to interpret legislation or relevant codes of ethics or professional conduct.

7. CONCLUSION

In this chapter, the Commission has set forth alternative approaches to law reform in the context of the new reproductive technologies, namely, the "private ordering" approach and the "state regulation" approach. Insofar as the latter is concerned, the relative merits of prohibition and regulation have been discussed; and, in the context of regulation, we have examined various instruments that the state may call upon when intervening in our affairs. In all cases, the Commission has rejected extreme positions, opting instead for a more eclectic, flexible approach.

The effect of the new reproductive technologies on basic human values is multidimensional, and constantly changing in concert with rapid advances in medical science. In the general approach we take and in our specific proposals for reform, we attempt to marry our perception of prevailing, although shifting, community norms and what we believe to be sound, progressive law reform.

CHAPTER 5

REFORM AND PROPOSALS FOR REFORM IN OTHER JURISDICTIONS

During the past several years, the popular media as well as various medical, legal, and other learned journals in Canada, the United States, the United Kingdom, Australia, and elsewhere have shown an increasingly avid interest in human artificial conception. In addition, law reform bodies in Alberta, Saskatchewan, and England, a special royal commission in British Columbia, several Canadian, American, and British umbrella organizations representing the medical profession, and numerous governmental and *quasi*-governmental committees have had, as their mandate, the study of one or more aspects of the artificial conception technologies. Finally, legislation and regulatory guidelines have been adopted or proposed in Canada, the United States, and Australia in respect of these technologies.

The reform measures and proposals for reform discussed briefly in this chapter — and reviewed in some detail in the Appendix to this Report — cover a variety of medical, legal, ethical, social, and other issues. The earlier studies dealt with artificial insemination alone — at one time the only artificial conception technique available — while later investigations turned their attention to such matters as *in vitro* fertilization, *in vivo* fertilization and lavage, and the storage of human sperm. Several of the reports, including one from Queensland and one from the United Kingdom, are reasonably comprehensive in scope, having regard to rapid advances in the state of the art; many more have considered only selected aspects of the new reproductive technologies.

Existing and proposed legislation seems, more or less, to be following the same general pattern. Legislation has focused mainly, although not exclusively, on what may be considered to be the simplest and least controversial of the new technologies — artificial insemination. Only recently has new legislation been passed in the United States and Australia touching on I.V.F. Several attempts by individual legislators in the United States to have surrogate motherhood legislation enacted — more precisely, to have the practice regulated or prohibited — have not yet met with any success.

While it is not intended in this chapter to canvass in detail the many developments in other jurisdictions, special mention ought to be made at this juncture of the most significant reform measures and proposals for reform.

Perhaps the most comprehensive study to date has recently been published in the United Kingdom. In July 1984, the governmental Committee of Inquiry into Human Fertilisation and Embryology issued a major Report examining the social, ethical, and legal implications of the new reproductive technologies.[1] The Report covered such controversial topics as surrogate motherhood and embryo research, as well as artificial insemination, I.V.F., gamete and embryo donation, and the storage of gametes and embryos.

Yet another significant contribution to the growing reform literature on the subject was published in Queensland in 1984. The *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters*[2] was, like the United Kingdom Report just mentioned, comprehensive in scope, dealing with the ethical, social, economic, political, and legal issues raised by the artificial conception technologies. Both of these wide-ranging studies have served to focus attention on critical policy issues addressed in this Commission's Report.

In addition, there have been several legislative enactments. Mention should be made here of the American Uniform Parentage Act[3] and new legislation in Victoria[4] and New South Wales.[5] These statutes do not purport to be comprehensive in scope; with one exception, they deal essentially with the legal status of an artificially conceived child. However, their mere existence — as well as their focus on so vital a question as status and paternity — attests to the growing public concern for the implications of artificial conception.

As we have said, it is important to bear in mind that the vast majority of the reports and statutory provisions dealing with artificial conception do not purport to address all the issues falling within this topic. Yet, despite this limitation, there are some common threads. The most obvious concern pervading the material reviewed by the Commission relates to the general absence of legal and other guidelines in respect of the new artificial conception technologies, a matter to which reference was made in chapter 3 of this Report. Notwithstanding the diversity of views in the community pertaining to the management of these technologies, there appears to be general agreement that they should not remain unregulated — that the law, and particularly the legal status of all persons involved, ought to be clarified. The recently published United Kingdom Report, to which reference has already been made, summed up this plea for reform in the following way: "What is common ... is that people generally want *some principles or other* to govern the development and use of the new techniques".[6] In the reports and legislation canvassed by the Commission, there is a decided preference for the state regulation approach, in some form or to some degree or another, and a rejection of the unregulated private ordering approach.

---

[1] United Kingdom, Department of Health and Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (Cmnd. 9314, 1984) (hereinafter referred to as "Warnock Report").

[2] Queensland, *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters* (1984).

[3] National Conference of Commissioners on Uniform State Laws, Uniform Parentage Act, Uniform Laws Annotated, Vol. 9A.

[4] *Status of Children (Amendment) Act* 1984, No. 10069, and *Infertility (Medical Procedures) Act* 1984, No. 10163.

[5] *Artificial Conception Act, 1984,* Act No. 3, 1984. See, also, *Children (Equality of Status) Amendment Act, 1984,* Act No. 6, 1984.

Not only is there more or less universal agreement that the law has not yet established satisfactory limits within which the new reproductive technologies should operate, there is a very large measure of consensus concerning many of the details of regulation, at least insofar as the more "traditional" artificial conception techniques — artificial insemination and I.V.F. — are concerned.

Perhaps much of the consensus follows from acceptance of the view, running through the published studies and implicit in the relevant legislation, that the law must protect the artificially conceived child and promote the child's welfare and best interests. This concern for the anticipated child manifests itself in several areas. We need mention but a few to illustrate the point.

One of the most pervasive topics considered in the voluminous literature, reports, and legislation emanating from other jurisdictions relates to the question of paternity and the legal status of the artificially conceived child where donor sperm is used. All the reports that address the issue recommend, and legislation in Quebec, the Yukon Territory, many American states, Victoria, and New South Wales, provides, that the A.I.D. child should be treated in law as the child of the husband or partner of the artificially inseminated woman, where the husband or partner has consented to the insemination. In addition, the semen donor is deemed not to be the legal father of the child.

In some cases, the consent of the husband or partner is to be presumed, although the presumption is rebuttable. In other cases, prior written consent is required. In yet other instances, no mention is made of the form of the consent. However, in no case has it been recommended or provided that a dissenting husband or partner should be deemed in law to be the father of the child, even where, because of the excluded status of the semen donor, the child would have no legal father.

The virtually universal concern for the welfare of the artificially conceived child has also manifested itself, to a greater or lesser extent, in a wish to control the selection of prospective parents who are thought to be suitable, socially and psychologically as well as medically, to participate in an artificial conception programme.

Leaving aside the reaction of those individuals and groups who, for religious, moral, or other reasons, wish to prohibit the use of artificial reproduction techniques in all cases, there have been relatively few questions concerning eligibility where only the gametes of a participating married couple are used. The studies generally assume that A.I.H. is an acceptable practice because no third party is involved.

---

[6] Warnock Report, *supra*, note 1, para. 5, at 2 (emphasis in original).

More controversial, however, has been the question of eligibility where donor gametes are used. But, even here, the leniency in respect of married couples is universal. The reports and legislation are unanimous in permitting married couples to undergo the appropriate procedure. The notion that such participation constitutes a violation of the sanctity of the marriage — even adultery — while discussed in several of the studies, has been rejected in favour of a more liberal approach.

This trend towards acceptance of the new opportunities opened up by modern scientific and medical advances is also generally, although not quite universally, reflected in the attitude to participation by unmarried couples. Many of the reports espouse the view that, as a general proposition, children are better served in a two parent family, with a father and a mother. In light of recent changes in a great many jurisdictions respecting the legal "recognition" of what has been called common law unions, most of the artificial conception reports and legislation have accepted the idea that a man and a woman who are not married, but who live together in a stable relationship, ought not to be precluded from participating in an artificial reproduction programme. Indeed, more often than not, the terms "husband" and "wife" are defined to include unmarried persons living in the manner just described.

Far more controversial, of course, is the status of single persons not living in such a manner, or lesbian couples. The vast majority of artificial insemination statutes are directed toward "married" women; but it is important to note that this restriction is relevant only in terms of the legitimacy issue. That is to say, while the provisions may restrict the legitimization of artificially conceived children to the case where the mother is "married", these provisions do not, in themselves, preclude the artificial insemination of, for example, single women.

With respect to access to artificial conception services, the general emphasis in the published studies — or at least in those that do not recommend at the outset that artificial conception services should not be available to single women — is on the desirability of a two parent family and on the stability of the relationship between the recipient and her spouse or partner. The imposition of a duty to screen potential candidates in respect of their emotional stability is justified, implicitly or explicitly, by the need to protect the future child — to ensure as much as possible that the child will be placed in the healthiest physical, emotional, and social environment.

With very few exceptions, there is no explanation offered concerning why such an invasion of privacy is thought to be acceptable and required in the context of artificial reproduction, but to be eschewed in the natural reproduction context. In some cases, passing comments are made to the effect that, where physicians and others must assist in the conception of a child by means of artificial conception techniques, they necessarily assume an additional, extra-medical burden *vis-à-vis* the future child. However, the reports generally do not elaborate on the subject. They do not, for example, explain why screening is thought to be necessary where the assistance is by means of one of the new reproductive technologies, but is not thought to be required where more traditional means of assistance, such as surgery or so-called "fertility pills", are utilized.

Moreover, it is ordinarily assumed, again without much explanation, that the selection process is ultimately to be under the control of the attending physician. While the studies that deal with the matter do stress the importance of counselling — frequently by experienced genetic counsellors or other specially trained persons — final responsibility for screening potential participants is to rest with the doctor, who must necessarily make difficult psychological, sociological, moral, ethical, and other nonmedical judgments in order to assess the suitability of the person or persons involved. In only one instance is there a suggestion that individual members of the medical profession may not, in fact, be well equipped to engage in such a vital decision-making process without some form of guidance or regulation.[7]

Yet another area canvassed in the reports under review — and, again, one that reflects, in large part, the general concern for the welfare of the artificially conceived child — is that of medical records and confidentiality. The studies frequently note the tension between the need to keep comprehensive medical records and the need to preserve the confidentiality of much of the information contained within such records.

One important aspect of this topic concerns whether the child should have access to information concerning, for example, the fact of artificial conception, the donor's characteristics, including medical and genetic information, and the donor's name and whereabouts. Many of the reports do acknowledge the increasing tendency in adoption law to permit an adopted child to discover his origins. However, while recognizing this trend, the studies display considerable concern that the release of information even indicating the fact that the child was artificially conceived may have serious emotional consequences for the child. On the other hand, it has been pointed out that secrecy also has a cost, particularly where, in the heat of a family quarrel, for example, the biological origins of the child are revealed in anger or as a means of distancing the child from one parent or another.

The question whether the donor's name should be available to the child raises even more serious issues. Again, the studies express some sympathy for children seeking to discover their natural parent or parents; however, the reports are clear that donor anonymity should be preserved. Apart from any harm that disclosure may cause the child, it is believed that knowledge or suspicion that such confidentiality may be violated may terminate the donation of gametes.

There is one area, however, in respect of which several reports have accepted a linkage between donors, recipients, and children. It is frequently stated that there should be access by the child or his parents to non-identifying medical information concerning the donor, so that such information may be used in treating the child for disorders that may be linked to the donor. But here, as indicated, the linkage would not disclose critical identifying information that might expose the donor to embarrassment or legal action.

---

[7] Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Issues Paper on Donor Gametes in IVF* (1983), para. 3.2.8, at 16.

The above discussion has centred mainly on a few areas, covered by recent studies and legislation, that impinge more or less directly on the welfare of the anticipated child. There are, however, matters that are less directly related to the child. For example, a major topic of concern is research and experimentation on fertilized ova outside the body. Indeed, it is in this area that many of the studies have been most desirous of ensuring adequate public control — usually through licensing requirements — of the activities of medical personnel and their colleagues.

At the present time, more than twenty American states have enacted statutes that deal with fetal experimentation and research. Some of the statutes preclude research and experimentation on, for example, "surplus" fertilized ova, that is, fertilized ova that are not to be transferred to a woman. In a few areas, persons are prohibited from selling, giving away, or permitting someone else to use, fetuses.

Several of the reports propose a maximum period — for example, fourteen days after the ovum is fertilized — beyond which no one may conduct any research or experimentation on an embryo, even with the approval of the gamete donors. Other reports consider in some detail the storage and control of embryos, including whether, and on what basis, they may be disposed of if not transferred. In most cases, however, there is no indication concerning what disposition may take place where there is no agreement by the donors, although in one report it is specifically recommended that the right to determine the use or disposal of the embryos should pass to the storage authority where the donors cannot agree.[8]

As indicated earlier, in this chapter we cannot canvass in any detail the full range of matters touched on by the reports and legislation from other jurisdictions; we leave such a discussion to the Appendix of this Report. Suffice it to reiterate here the common expression of concern about the continued unregulated use and development of artificial conception techniques. While the specific mandate or terms of reference of each commission or body examining the topic may be more or less restricted in scope, each report evinces a keen desire to balance society's acceptance of new medical advances with a reasoned view concerning the limits that ought to be imposed on such advances.

No report or study has welcomed the unfettered use of all that medical science has to offer. The rationale is always the same and, clearly, has nothing to do with medicine and science: it is that certain moral, ethical, or normative principles must override the dictates of technology. Perhaps this is most clearly evidenced by the general rejection of surrogate motherhood as a means of circumventing the effects of infertility. Whether the justification is the desire to preclude the exploitation of financially distressed women, or the belief that surrogate motherhood violates acceptable community standards respecting the family, or the view that there is too great an opportunity for emotional harm to all parties concerned — the resulting child, the surrogate mother, her children, and others — the reports and studies generally advance the opinion that, as a matter of policy, surrogacy represents a critical threshold that should not be crossed.[9]

---

[8] See Warnock Report, *supra*, note 1, para. 10.13, at 56-57.

Such a relatively widely-held view contrasts sharply with the increasing acceptance of the more "traditional" means of artificial conception, that is, artificial insemination and I.V.F. Here, the quest is largely to regulate, rather than prohibit, the practice, bearing in mind several critical policy and practical considerations. Insofar as many of the details of such regulation are concerned, there is a rather large measure of consensus among the commissions and committees concerned with the subject. Whatever the rationale, this relative harmony seems to reflect a growing professional and public familiarity with the technologies and an increasing ethical acceptance of their place in society.

---

[9] See, also, Victoria *Infertility (Medical Procedures) Act* 1984, *supra*, note 4, s. 30.

Volume

2

REPORT

ON

HUMAN ARTIFICIAL REPRODUCTION AND RELATED MATTERS

ONTARIO LAW REFORM COMMISSION

Ontario

VOLUME II

---

inistry of the
ttorney
eneral

1985

The Ontario Law Reform Commission was established by the *Ontario Law Reform Commission Act* for the purpose of reforming the law, legal procedures, and legal institutions. The Commissioners are:

James R. Breithaupt, CStJ, CD, QC, MA, LLB, *Chairman*

H. Allan Leal, OC, QC, LLM, LLD, DCL, *Vice Chairman*

Honourable Richard A. Bell, PC, QC, LLD

William R. Poole, QC

Barry A. Percival, QC

M. Patricia Richardson, MA, LLB, is Counsel to the Commission. The Secretary of the Commission is Diane L. Murdoch. The Commission's office is located on the Fifteenth Floor at 18 King Street East, Toronto, Ontario, Canada M5C 1C5.

During the course of the Reference on Human Artificial Reproduction and Related Matters, the Chairman, Dr. Derek Mendes da Costa, QC, left the Commission to take up an appointment as Judge of the Unified Family Court. Accordingly, while the Commission benefited greatly from Dr. Mendes da Costa's knowledge and experience and wishes to express its indebtedness to him, the recommendations contained in this Report do not necessarily reflect his views and cannot be attributed to him.

ISBN 0-7729-0001-9 (for set of two volumes)
ISBN 0-7729-0003-5 (Volume II)

TABLE OF CONTENTS

VOLUME I

Page

Letter of Transmittal xi

Glossary of Terms as Used in this Report xiii

Chapter 1 INTRODUCTION 1

Chapter 2 INFERTILITY IN ONTARIO: INCIDENCE, CAUSES, AND RESPONSES 9

1. Meaning of "Infertility" 9
2. Incidence and Causes of Infertility 10
3. Treatment of Infertility 14
   (a) Conventional Responses 14
      (i) Conventional Therapy 14
      (ii) Adoption 15
   (b) Non-Conventional Therapy 17
      (i) Artificial Insemination 17
      (ii) *In Vitro* Fertilization (I.V.F.) and *In Vivo* Fertilization Followed by Lavage 24
4. Conclusions 28

Chapter 3 PRESENT LAW IN ONTARIO AND THE CASE FOR REFORM 29

1. Introduction 29
2. Artificial Conception Services as the Practice of Medicine 30
3. Eligibility to Participate in Artificial Conception Programmes 36
   (a) International Provisions 36
   (b) National Provisions Relating to Discrimination and Civil Rights 39
      (i) *Canadian Charter of Rights and Freedoms* 39
         a. General 39
         b. The Prohibition of Artificial Conception Technologies: Is There a Right to Procreate? 41

c. Discrimination in Access to the Reproductive Technologies 45
(ii) *Human Rights Code, 1981* 46
(iii) Conclusion 50
(c) The Canadian Medical Association *Code of Ethics* 51
(d) *Health Disciplines Act* and *Public Hospitals Act* 53
4. The Donation of Gametes 59
(a) The Individual Donor 60
(b) Sperm Banks 62
(c) Conclusion 63
5. Status of the Child, Parentage, and Birth Registration 64
(a) The Law and Practice Respecting Registration of Births Under the *Vital Statistics Act* 65
(b) The Establishment of Parentage Outside the *Vital Statistics Act* 73
(c) Birth Registration, Inheritance Rights, and the Posthumously Conceived A.I. or I.V.F. Child 75
(d) Conclusion 76
6. Medical Records: Composition, Retention, Access, and Confidentiality 78
7. Research and Experimentation on Human Genetic Material 83
8. Surrogate Motherhood: Contracts to Transfer Custody of Children and Parental Rights and Obligations 91
(a) Common Law Background 92
(b) The Present Position in Ontario 94
9. Conclusion: The Case for Reform 102

Chapter 4 ALTERNATIVE APPROACHES TO REFORM 105
1. Introduction 105
2. The "Private Ordering" Approach 107
3. The "State Regulation" Approach 110
(a) General 110
(b) Adoption Law in Ontario: A Model of State Regulation.... 111
4. The Present Ontario "Approach": A Disavowal of Extremes 117

5. Conclusions Respecting the General Approach to Reform 118

6. Ancillary Issues 123

   (a) Prohibition or Regulation? 123

   (b) The Instruments of Regulation 125

7. Conclusion 130

Chapter 5 REFORM AND PROPOSALS FOR REFORM IN OTHER JURISDICTIONS 131

VOLUME II

Glossary of Terms as Used in this Report xi

Chapter 6 PROPOSALS FOR REFORM 139

1. Introduction 139

2. The Propriety of Artificial Conception Technologies 140

3. General Recommendations for Reform 149

   (a) Artificial Conception Services as the "Practice of Medicine" 149

   (b) Eligibility for Participation in an Artificial Conception Programme 153

      (i) Criteria for Assessment: Marital Status and Other Matters 153

      (ii) The Refusal of Artificial Conception Services: Complaints and Appeals 159

   (c) The Donation of Gametes 160

      (i) Criteria for Selection of Donors 160

      (ii) Minors as Gamete Donors 162

      (iii) Consent of Gamete Donors 164

      (iv) Revocation of a Donor's Consent 166

      (v) Payments to Donors 167

      (vi) Frequency of Use of Donors 169

      (vii) Sperm, Ova, and Embryo Banks 171

      (viii) Importation of Gametes and Embryos from Outside Ontario 173

   (d) Status of Artificially Conceived Children: Parentage, Birth Registration, and Inheritance Rights 174

    (i) Parentage of Artificially Conceived Children 174
        a. Legal Status of Social Parents and Gamete Donors 174
        b. The Nature and Form of a Husband's or Partner's Consent 176
    (ii) Retroactive Recognition of Parentage 178
    (iii) Registration of Birth 178
        a. Where Donor Gametes are Used 178
        b. Posthumous Artificial Conception, Where No Donor Gametes are Used 179
    (iv) Inheritance Rights of Artificially Conceived Children 180
        a. Where Donor Gametes are Used 180
        b. Posthumous Artificial Conception, Where No Donor Gametes are Used 182
  (e) Medical Records 183
  (f) Artificial Conception and Legal Liability 190
    (i) Concealment and Misrepresentation of Information by Gamete Donors 190
    (ii) Products Liability and the Supply of Gametes and Embryos 191
    (iii) Wrongful Conception, Wrongful Birth, Wrongful Life, and Dissatisfied Life Claims 194
4. Proposals Relating to the Fertilized Ovum Outside the Body 198
  (a) Introduction 198
  (b) The Simultaneous Transfer of Multiple Ova 199
  (c) Control of a Fertilized Ovum Outside the Body 199
    (i) General 199
    (ii) Where No Donated Gametes are Used 203
    (iii) Where Donated Sperm or Ova, or Both, are Used ... 204
  (d) The Role of Gender Selection in the Transfer of a Fertilized Ovum 207
  (e) Research and Experimentation on a Fertilized Ovum Outside the Body 207
    (i) General 207
    (ii) Transfer of Fertilized Ova Previously Subjected to Research or Experimentation 212

- (f) Time Limits on the Development and Storage of Fertilized Ova 214
- (g) The Cryopreserved Fertilized Ovum and the Rule Against Perpetuities 217

5. Proposals Relating to Surrogate Motherhood 218
- (a) Introduction 218
- (b) Approaches in Other Jurisdictions 221
- (c) Policy in Principle 229
- (d) Choice of a Regulatory Scheme 233
- (e) The Proposed Regulatory Scheme 236
  - (i) The Prospective Parents 236
    - a. Medical Indications for Approval 236
    - b. Assessing the Parents: Marital Status and Other Factors 237
    - c. Use of Gamete Donors 239
  - (ii) The Surrogate Mother 239
    - a. Eligibility to Act as a Surrogate Mother 240
    - b. Assessment of Prospective Surrogate Mothers 241
  - (iii) The Court 242
    - a. Standard of Proof for the Approval of Agreements 243
    - b. The Prospective Surrogate Mother as a Co-Applicant 244
    - c. Blood, Tissue and Other Testing of Parentage 245
    - d. Participation of the Children's Aid Society 247
    - e. Confidentiality of the Proceedings and the Court Record 248
  - (iv) Terms of the Agreement 249
    - a. Surrender of the Child 249
    - b. Payment to the Surrogate Mother 253
    - c. Birth of a Handicapped Child 255
    - d. Abortion and the Surrogate Mother 257
    - e. Residual Terms of Surrogate Motherhood Agreements 259
  - (v) Status and Inheritance Rights of the Child 260
  - (vi) Agencies Arranging Surrogate Motherhood Agreements 261

(vii) Miscellaneous Issues 263

- a. Failure of Flushing to Remove an *In Vivo* Fertilized Ovum 263
- b. Introduction of Replacement Surrogate Mothers ... 264
- c. Recognition of Surrogate Motherhood Agreements Made Outside Ontario 265
- d. Medical Records 267

(viii) Failure to Comply with the Proposed Scheme 267

- a. Penalties 267
- b. Status of Children of Unapproved Surrogate Motherhood Arrangements 270

6. Further Review 272

SUMMARY OF RECOMMENDATIONS 275

VICE CHAIRMAN'S DISSENT 287

CONCLUSION AND ACKNOWLEDGMENTS 293

1. Conclusion 293
2. Acknowledgments 293

APPENDIX REFORM AND PROPOSALS FOR REFORM IN OTHER JURISDICTIONS 295

1. Introduction 295
2. Research and Reports 295

(a) Canada 295

- (i) British Columbia, Royal Commission on Family and Children's Law 295
- (ii) Alberta, Institute of Law Research and Reform 300
- (iii) Health and Welfare Canada, Advisory Committee on the Storage and Utilization of Human Sperm 300
- (iv) Law Reform Commission of Saskatchewan 304

(b) United Kingdom 311

- (i) United Kingdom, Department of Health and Social Security, Scottish Home and Health Department, and Welsh Office 311
- (ii) British Medical Association, Board of Science and Education, Panel on Human Artificial Insemination 313

(iii) British Medical Association, Working Group on In Vitro Fertilisation 315

(iv) Medical Research Council 318

(v) Royal College of Obstetricians and Gynaecologists, Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer 318

(vi) The Law Commission 324

(vii) England, The Law Society, Standing Committee on Family Law, Human Fertilisation and Embryology ... 326

(viii) Law Society of Scotland 328

(ix) Department of Health and Social Security, Committee of Inquiry into Human Fertilisation and Embryology 331

(c) Australia 343

(i) Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization 343

a. *In Vitro* Fertilization, Artificial Insemination, and Donor Gametes 343

b. *In Vitro* Fertilization and "Surplus" Embryos 352

(ii) Queensland, Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters 357

(iii) South Australia, Working Party on In Vitro Fertilization and Artificial Insemination by Donor 366

(d) United States 370

(i) The American College of Obstetricians and Gynecologists 370

(ii) The American Fertility Society 371

3. Legislation 372

(a) Introduction 372

(b) Canada 374

(i) Quebec 374

(ii) Yukon Territory 375

(c) United States 375

(i) Artificial Insemination 375

a. General 375

b. Issues Addressed by Artificial Insemination Legislation 377
    (1) Married v. Single Women 377
    (2) Consent 378
    (3) The Donor 379
    (4) Medical Records 380
    (5) The Performance of Artificial Insemination and Its Implications 380
(ii) *In Vitro* Fertilization, Embryo Transfer, and Fetal Research 380
(d) Australia 383
    (i) Victoria 383
    (ii) New South Wales 389

GLOSSARY OF TERMS AS USED IN THIS REPORT

Amniocentesis	Withdrawal from the amniotic sac of a small sample of the fluid surrounding the growing fetus in order to detect certain fetal abnormalities.
Conceptus	Product of conception, that is, the embryo and membranes.
Embryo	An organism in the the early stages of development before recognizable human features have been formed.
Fallopian tubes	Tubes through which ovulated ova, which have been released from the ovaries, are transmitted into the uterus.
Fertilized ovum	Used interchangeably with "embryo".
Fetoscopy	Visual inspection of a fetus in the uterus.
Fetus	The developing embryo which has achieved recognizable human features (from the end of the eighth week to the moment of birth).
Gamete	An ovum or sperm.
Gene	A unit of heredity.
Implantation	The attachment of the fertilized ovum to the uterine wall.
Laparoscopy	Visual examination of organs by insertion of a light guide through a small incision in the abdominal wall. In this Report, "laparoscopy" is used to refer to the entire procedure by which ova are first visualized, and then recovered by a special needle fitted with a suction apparatus.
Lavage	The technique of "washing out" a fertilized ovum from a woman's uterus before implantation.
Ovum (pl. ova)	The female sex cell.
Semen	Fluid secretion containing sperm emitted during ejaculation.
Sperm	The male sex cell.
Ultrasound	Visualization of internal bodily structures by reflection of ultrasound waves.

CHAPTER 6

PROPOSALS FOR REFORM

1. INTRODUCTION

In earlier chapters of this Report, the Commission examined the incidence and causes of infertility and considered the medical and legal milieu in which infertile men and women, gamete donors, doctors, lawyers, and others attempt to resolve this substantial, and apparently growing, problem. We need not repeat here the case for a fundamental re-examination and reform of a legal framework that basically ignores or deals only inadvertently with continuing advances in medical reproductive technology. It is enough to reiterate our conclusion that clear legal rules must be formulated to deal with artificial conception — rules that, as we said in chapter 4, are in concert with both normative standards generally acceptable to the community and sound, progressive law reform.

In this chapter, the Commission will discuss various issues that have been identified during the course of this Project, and offer recommendations for reform. In this connection, it bears repeating that the Letter of Reference from the Attorney General for Ontario requires that we report on the range of alternative solutions to *legal* issues. However, as we stated in the Introduction to this Report, legal questions inevitably have non-legal dimensions and cannot be divorced from moral, ethical, social, and psychological questions, particularly where, as in the case of artificial reproduction, the non-legal component is so vitally important. But, in the end, after examining these matters, our proposals for reform deal essentially with the legal environment within which the new reproductive technologies should function.

The approach adopted in this chapter is, first, to address, on a functional basis, the matters that are common to the three reproductive technologies in issue, that is, artificial insemination, *in vitro* fertilization, and ovum donation by means of *in vivo* fertilization and lavage. We shall then consider several issues that relate exclusively to the human embryo outside the body. Finally, in a separate section, the Commission will set forth its recommendations concerning the special case of surrogate motherhood.

We begin our discussion with a consideration of the propriety of the various artificial conception technologies, excluding surrogate motherhood, which simply makes use of one of the technologies. Clearly, the examination of the different issues pertaining to the technologies depends upon a determination that each one is ethically and socially acceptable.

2. THE PROPRIETY OF ARTIFICIAL CONCEPTION TECHNOLOGIES

The reports summarized by the Commission in the Appendix to this Report make manifest the centrality of the question concerning the social and ethical propriety of artificial insemination, I.V.F., and gamete donation (including *in vivo* fertilization and lavage). While the reports, emanating from diverse sources and responding to different terms of reference, are not entirely uniform in their treatment of this vital issue, we are struck by the general endorsement of the new reproductive technologies by medical and legal organizations and by committees composed of medical and legal experts, social workers, psychologists, and others. Their acceptance, while not necessarily enthusiastic, ordinarily goes beyond mere resignation to what is perceived to be the inevitable. The general acceptance of the technologies is founded ultimately on their use as a beneficial — indeed, as emphasized in several cases, a necessary — medical procedure to circumvent the problem of male and female infertility.[1] However, notwithstanding this general predisposition in favour of artificial conception, it is noteworthy that a few committees have sought in some cases to preclude, or, what is more usual, to impose special restrictions on, the use of one or more of the procedures.[2]

Differing attitudes to artificial insemination, I.V.F., and *in vivo* fertilization and lavage, and to the use of donor gametes, reflect a great variety of social, ethical, and practical factors. Such factors include the simplicity or complexity of the procedure (and, therefore, the extent of medical intervention and the medical risks involved), the corresponding ability of laypersons to use a particular procedure without medical instruction or supervision, and the extent to which a procedure is regarded as an unacceptable deviation from the "natural" process of human reproduction or from the "normal" concomitants of marriage. A perusal of the relevant, now voluminous, literature reveals the pervasive notion that scientific possibility cannot, and should not, determine ethical or social acceptability: the mere fact that advances in medicine are now able to remedy the effects of infertility is not perceived to be a conclusive argument in favour of any practice considered to be unacceptable by the community. We concur in this view of science and public policy.

---

[1] See, for example, Medical Research Council, "Research related to human fertilisation and embryology" (1982), 285 Brit. Med. J. 1480 (hereinafter referred to as "M.R.C. Statement"), at 1480; Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on Donor Gametes in IVF* (1983) (hereinafter referred to as "Victoria Report on Donor Gametes"), para. 6.32, at 47; and Canada, Health and Welfare Canada, *Report of the Advisory Committee on the Storage and Utilization of Human Sperm* (1981) (hereinafter referred to as "Health and Welfare Canada Report"), at xi.

[2] See, for example, the special rules recommended for ovum donation in Queensland, *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters* (1984) (hereinafter referred to as "Queensland Report"), at 138-41. In a recent report by a committee in the United Kingdom, it was recommended that "the technique of embryo donation by lavage should not be used at the present time" or until the risks of donation by this method have been overcome: United Kingdom, Department of Health and Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (Cmnd. 9314, 1984) (hereinafter referred to as "Warnock Report"), para. 7.5, at 40.

While we do not believe that the question respecting the ethical and social propriety of the new reproductive technologies must necessarily be answered in the same way for each procedure, we are of the view that there are arguments, both for and against, that may be marshalled generally in respect of all means of artificial conception. It is to these common features that we now turn, after which we shall direct our attention to any unique aspects of individual technologies that may affect our conclusions.[3]

For some, the question of the propriety of the new procedures cannot be divorced from the issue of eligibility, dealing, *inter alia*, with whether otherwise ethically acceptable artificial conception procedures ought to be made available only to legally married couples, or whether "common law" couples and single women should also be eligible for participation. For the most part, however, we shall leave eligibility for subsequent discussion.[4] In a sense, this issue, while clearly of critical importance, forms but one aspect of the central question concerning the propriety of the new reproductive technologies themselves.

We begin first with what may now appear to be several rather trite, but nonetheless necessary, observations respecting the rationale for artificial conception: the bearing of children is regarded generally as vitally important, both at an individual and at a societal level; infertility is a disease affecting a very sizeable proportion of the child-bearing population; the treatment of infertility by surgery, drugs, or other traditional medical means cannot alleviate the plight of all infertile persons; fertile people may risk dysgenic reproduction by natural means; the number of infants available for adoption cannot meet the demand of infertile persons for children; and the new artificial conception technologies now offer hope for those who wish to have children but whose medical problems are not amenable to a solution by any other means.

That there are considerable public anxieties — based on ethical, moral, social, medical, and legal concerns — and, therefore, substantial controversy respecting the new techniques, does not, of course, detract from the very simplicity of the fundamental argument in favour of artificial conception. This ought not to come as a surprise. The unadorned nature of the argument reflects the basic goal and function of medical science, that is, to cure disease or alleviate its effects. To suggest that childlessness or dysgenic reproduction must simply be accepted as a necessary, albeit unfortunate, physical evil, and accordingly to prohibit treatment by means of artificial conception, would, in one sense, place infertility in a rather special category of affliction. It would do so because, under such a regime, it would be a disease for which treatment is possible, relatively safe, and often uncomplicated, but simply not permissible.

---

[3] A very useful examination of the arguments for and against the various technologies and procedures appears in the Warnock Report, *supra*, note 2, paras. 4.2-4.3, at 17-18 (A.I.H.); paras. 4.6-4.15, at 18-23 (A.I.D.); paras. 5.6-5.9, at 31-32 (I.V.F.); paras. 6.4-6.5, at 36 (egg donation); and paras. 7.2-7.3, at 39-40 (embryo donation).

[4] See *infra*, this ch., sec. 3(b)(i).

To preclude the use of a practicable and safe medical treatment clearly demands the existence of very compelling ethical, moral, and social arguments, for such prohibitory action runs counter not merely to the basic purpose of medicine, accepted by the community at large, but also to the goal of modern Western societies to provide for the welfare and betterment of their members.

It would seem that at the core of the argument espoused by many persons against the use of artificial conception lies the view that such conception is somehow "unnatural", that it violates the "natural" means of procreation: families should be founded and children conceived only by means of sexual intercourse. Allied to this view is the notion that marriage itself — the "bedrock" of the family — demands a coincidence between sexual intercourse and procreation. Many who hold these opinions have translated them into an absolute moral code that governs their reaction (that is, their fundamental antipathy) to all forms of artificial conception, whether or not performed within a marital union and whether or not donor gametes are used.

As we have said in other portions of this Report, the Commission acknowledges and respects the views of those persons who, for moral, ethical, social, or other reasons, reject the propriety of the new reproductive techniques *en masse*. However, the sincerity or tenacity with which they hold this opinion does not alter the simple fact that they espouse a view of *public* policy, as opposed to individual morality, that the Commission and, we believe, a majority of the community, do not share.

In the first place, we are greatly concerned about the plight of persons with genetically transmissible diseases and of infertile men and women who wish to found a family and, for medical reasons, cannot do so. Their frustration and lack of physical and emotional well-being are very real, and often threaten their stability and their relations with others. The welfare of such persons should not be denigrated by the suggestion, frequently voiced, that the time and effort expended on their incapacity would be better spent on the treatment of life-threatening or more debilitating diseases. As the Warnock Report stated, it is now accepted that the goal of medicine goes well beyond the preservation of human life.[5]

But, beyond any practical or utilitarian rationale for accepting the place of artificial conception in our society, we reject the contention that the treatment of infertility in this manner is "unnatural". If the proposition is merely meant to imply that the use of the new techniques constitutes an interference with nature, we vigorously question the import of this criticism: surely the medical treatment of any ailment by drugs, surgery, or other means must equally come under similar attack. As we have said, the role of medicine is precisely that — to interfere with the natural deterioration or malfunctioning of the body.

---

[5] Warnock Report, *supra*, note 2, para. 2.4, at 9. This viewpoint is exemplified in Ontario, for example, in the extent to which public funds are available under the Ontario Health Insurance Plan.

If, to probe deeper, it is suggested that artificial conception is "unnatural" essentially because it is an *unwarranted* interference with nature, we must respond, in part, as the Warnock Committee did, by noting "the ambiguity of the concepts 'natural' and 'unnatural' ".[6] The history of medicine and science bears witness to the constant tension between man's view of the "natural" (and, therefore, putatively correct) ordering of things and the attempts by doctors and scientists to dispel superstition and beliefs in the righteousness and immutability of the *status quo*. The "naturalness" of any particular thing or act is very much bound up with time and space. For an individual to eschew the new reproductive technologies because their existence and use violate his or her own moral or ethical code is one thing; to reject them on behalf of the larger community because they are somehow "unnatural" offers little, if anything, in the way of an argument founded on public policy considerations.

We also do not accept the arguments against artificial conception that, we have said, are allied to the fundamental one described above. For example, like several other committees before us,[7] we do not believe that separating intercourse from procreation violates the sanctity of marriage or of the family or evinces a breakdown in these relationships. Indeed, it has been contended that, given the frustrations of infertility or genetic risk and childlessness, the continuing desire to participate in an artificial conception programme manifests a deep commitment to the marriage and to the anticipated child.[8] There is, of course, no mathematical or other precise formula by which to measure the nature or level of such commitment, but we see no reason to accept the proposition that artificial conception *per se* is the forerunner of marital or family disharmony and dislocation.

The preceding views expressed by the Commission concerning the general propriety of artificial conception have not distinguished between the various technologies. We have focused essentially on basic principles rather than on any unique characteristics of the procedures.

But, clearly, there are certain differences that have given rise to particular concerns and sometimes, as a consequence, opposition, even where artificial conception has not been rejected generally on broader moral, ethical, or social grounds. For example, with respect to I.V.F., a major criticism of the use of the procedure centres around the disposition of any "surplus" embryos, that is, ova fertilized *in vitro*, originally intended to be used if necessary, but, as it happens, not actually transferred to the uterus of the woman. Many would found their rejection of I.V.F. on the basis that the implications or consequences of this fact -- the wastage of the embryos or, perhaps, their use for the purpose of experimentation — inevitably render the whole procedure morally unacceptable, or at least render it so where the guidelines of the hospital or clinic in question do not require the implantation of all fertilized ova.

---

[6] *Ibid.*

[7] See, for example, *ibid.*, para. 4.10, at 21, and paras. 4.14-4.15, at 22; Health and Welfare Canada Report, *supra*, note 1, at xi-xii, 1-2, 37, and 42-44; and Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Issues Paper on Donor Gametes in IVF* (1983), para. 3.2.6, at 14, and para. 3.2.7, at 16 (but see *ibid.*, para. 3.2.7, at 15, and para. 3.3.4, at 19).

[8] See *supra*, note 7.

Another argument that focuses attention on the consequences of the technique, rather than on fundamental ethical principles, relates to the donation of an ovum by means of *in vivo* fertilization and lavage. Leaving aside for the moment the argument based on a general rejection of gamete donation itself, it has been said that the risk of a resulting, unintended pregnancy in the ovum donor, because the embryo may not be washed out, is sufficient to warrant prohibition of this form of donation.[9]

Unquestionably, one of the arguments most strenuously advanced by opponents of artificial conception concerns the use of donor gametes. For some, a distinction is drawn between artificial conception without donor gametes and artificial conception with such gametes; for others, the fact of donation adds further emphasis to a more deep-seated moral antipathy to any type of artificial reproduction.

The arguments against such reproduction, based on the donation of gametes, may take several forms, for example, focusing on the effect of donation on the marriage, or focusing on its effect on the future child.

Whereas A.I.H. is the simplest and least controversial[10] of the technologies and, to most persons, is the closest to natural insemination (since, in both cases, the gametes of the spouses are brought together *in vivo*), A.I.D. and I.V.F. involving donor gametes are regarded by some as representing "the introduction of a third party into what ought to be an exclusive relationship".[11] As the Warnock Committee pointed out, this action is often seen as morally repugnant in itself and a threat to both the marriage and the family.[12] This, in turn, frequently leads to the conclusion that artificial conception with donor gametes is fundamentally harmful to society, which is based, it is said, on the twin social pillars of marriage and the family.

Not only is the use of donor gametes seen by some as a violation of the exclusivity inherent in a marital union and of the sanctity of the family, but it is also seen as harmful to the artificially conceived child. Again, there are several facets to this argument. For example, it is said that the wish of many parents to shroud the nature of the child's biological origins in secrecy is essentially a form of deception, which must be regarded as undesirable in itself, and which may detrimentally affect the emotional stability of the child and the parents.

---

[9] See Warnock Report, *supra*, note 2, para. 7.2, at 39, and para. 7.5, at 40. One study indicated that 8-10% of ovum donors by this method become pregnant: see Bustillo *et al.*, "Nonsurgical Ovum Transfer as a Treatment in Infertile Women: Preliminary Experience" (1984), 251 J. Am. Med. Ass'n 1171.

[10] See the views expressed in the various reports summarized in the Appendix to this Report.

[11] Warnock Report, *supra*, note 2, para. 4.10, at 20.

[12] *Ibid.*

However, at the same time it is also contended that openness and disclosure may be dangerous. Clearly, this may be so where the child's origins are divulged by accident, in the heat of a family quarrel, or in a custody or child maintenance dispute. But it has been suggested that children artificially conceived with donor gametes "may feel obscurely that they are being deceived by their parents, that they are in some way different from their peers, and that the men [or women] whom they regard as their fathers [or mothers] are not their real" parents.[13] Since certain persons are of the view that disclosure of origins is both inevitable and morally right in principle, but that only psychological harm can result from such disclosure, they are driven to the conclusion that artificial conception itself is the evil to be prohibited.

The Commission acknowledges the force of the arguments relating to the implications of gamete donation, particularly insofar as they deal with the likely or potential effects on the child. With respect to the consequences for a marriage, we recognize that pre-conception strains on an infertile or genetically diseased couple, and stress produced by undergoing artificial reproduction treatment, may be substantial and, in some instances, irremediable.

However, we wish to echo the conclusion of the Warnock Committee that "the donor is [not] *necessarily* a threat to the stability of the relationship" between husband and wife.[14] It is not possible to state categorically that all married persons will react adversely to gamete donation. Some clearly will react in this manner; others will not. But we are of the view that this possibility does not warrant the wholesale prohibition of artificial conception services involving donor gametes, a prohibition that would affect both stable and potentially unstable (and, therefore, unsuitable) couples. Rather, we believe that the guidelines that we shall subsequently recommend concerning eligibility to participate in an artificial conception programme will be sufficient to eliminate unsatisfactory participants.[15] Personal moral codes will serve to reduce further the candidates for the new reproductive techniques. But for many other persons, the social and psychological effects of infertility or the genetic hazards of natural reproduction are simply too great to warrant outright prohibition.

In a similar vein, the Commission has also come to the conclusion that the possible consequences of donation *vis-à-vis* the child are not such as to warrant prohibition merely because gametes are donated. As the Warnock Report stated, "[a]n AID child is a child very much wanted: a couple may have had to endure years of waiting and will consequently cherish the child".[16] We believe that this view is equally appropriate with respect to all the technologies. Obviously, no one can guarantee that the parents and the child will be able to deal with the fact of gamete donation in a satisfactory manner, no more than a similar guarantee is possible in the case of adoption. Once again, however, we wish to emphasize that our subsequent recommendations regarding eligibility for participation in an artificial conception programme are designed to ensure, as much as possible, that the child will be reared in a healthy home environment. As a society, we do far less for naturally conceived children.[17]

---

[13] *Ibid.*, para. 4.12, at 21.

[14] *Ibid.*, para. 4.11, at 21 (emphasis in original).

[15] See *infra*, this ch., secs. 3(b)(i) and (ii).

[16] Warnock Report, *supra*, note 2, para. 4.15, at 22.

The preceding consideration of the arguments for and against artificial conception reflects, for the most part, the main currents of thought on the subject. That is not to suggest that opponents of the new technologies have not focused attention on other aspects, such as, for example, the frequency of individual donor use, possible accidental incest or marriage involving a donor's children, and research and experimentation on embryos.

Insofar as these and other matters are concerned, the Commission has expressed its view that the proposals made in subsequent sections of this chapter are designed to meet these criticisms within a framework that is socially and ethically acceptable to the majority of the community. However, there is one procedure, alluded to earlier, that caused the Warnock Committee, and causes us, some particular concern. We pointed out that, where an egg is fertilized *in vivo* and then lavage is used, there is a relatively high risk of pregnancy in the embryo donor where the procedure does not succeed in washing out the embryo. This risk prompted the Warnock Committee to recommend that "the technique of embryo donation by lavage should not be used at the present time".[18]

As we have said, the nature and extent of the risk involved in the use of lavage is significant and of concern to us. However, there are factors that favour accepting this form of treatment. First, ovum donation by *in vivo* fertilization and lavage may be the only means by which a woman may be able to bear a child. In this connection, it should be mentioned that, in order to produce a donated egg where fertilization is to take place *in vitro*, the donated egg must be removed by surgery, with all its attendant risks. As the Warnock Committee stated, "[e]mbryo donation by lavage is, according to its advocates, much safer for the donor as it does not require general anaesthesia, and a simple and safer procedure is involved; moreover, for the embryo, there is the advantage of a shorter interval *in vitro* during which time it might deteriorate".[19]

Secondly, the risk of an unwanted pregnancy in the donor would be a matter to which the attending physician is required to direct the donor's attention, since she must give her free and informed consent to the procedure. Since, as we shall see,[20] our proposals would preclude minors from donating embryos in this fashion, the fear that the risk of pregnancy would not be completely understood or appreciated, or that the consent would somehow be suspect, should be dispelled. Accordingly, we see no reason to treat donation by lavage in a manner different from the manner in which we treat the other reproductive technology procedures. It bears mentioning that even the Warnock Committee did not reject the procedure as a matter of principle; its objection was basically that the technology has not yet developed to the point where the risk of pregnancy is acceptable.

---

[17] See, generally, *supra*, ch. 4, at text accompanying notes 1-4.

[18] Warnock Report, *supra*, note 2, para. 7.5, at 40. With respect to resulting pregnancies, see *supra*, note 9. The Warnock Committee was not enthusiastic about any form of embryo donation, but accepted the procedure where donated ova and sperm are brought together *in vitro*: *ibid.*, para. 7.4, at 40.

[19] *Ibid.*, para. 7.1, at 39.

Our conclusion in respect of the propriety of the artificial reproductive technologies should now be clear. We began this section with the simple argument in favour of their use and acceptability: for some persons, artificial conception — whether it is artificial insemination or I.V.F., and whether or not gametes or embryos are donated — offers the only opportunity of having a child.

Having rejected the notion that the new techniques are morally repugnant because they are "unnatural" procedures violating the sanctity of marriage and of the family, we believe that the fundamental arguments against artificial conception, whether ethical, moral or social, cannot prevail in the case of A.I.H. And we take this view not essentially because, as has been suggested by some, A.I.H. is, as an ethical matter, the closest artificial technique to natural reproduction. As we have indicated, we endorse the use of artificial conception technologies as legitimate and ethically acceptable advances in medicine, designed to alleviate the effects of infertility or genetic hazards and, therefore, to further the welfare of a relatively substantial segment of society. For this reason, then, we do not distinguish I.V.F. without donor gametes from A.I.H., insofar as the propriety of the procedure is concerned. While the greater complexity and far more substantial intervention by the medical profession in the case of I.V.F. may appear to represent a more significant departure from natural reproduction, the Commission would prefer not to view the question of its legitimacy in this way. It, too, is ultimately justified by its purpose, its use by persons committed to becoming parents, and its results.[21]

We have also rejected the argument that the use of donor gametes should fundamentally alter our view of the new technologies. Unlike adoption — which has become increasingly difficult in the case of infants — the use of donated sperm or donated ova permits a couple to have a child biologically related to one of them. Given this intimate connection and, as we shall see in a subsequent section,[22] given our recommendation that artificial conception procedures should be available, in the case of a couple, only where both parties, and the union, are stable, we believe that the prospects for the child are favourable indeed.

---

[20] See *infra*, this ch., sec. 3(c)(ii).

[21] See The Society of Obstetricians and Gynaecologists of Canada, "Statement on In-Vitro Fertilization and Embryo-Transfer", published in the Bulletin of the Society, Vol. VI, No. 3, May/June, 1984, at 4 (hereinafter referred to as "SOGC Statement"). The Society stated (at 4): "The Committee [on Endocrinology and Fertility] feels that In-Vitro Fertilization (IVF) is a recognized and acceptable form of treatment for infertility, not treatable by other means".

[22] See *infra*, this ch., sec. 3(b)(i).

Finally, we have concluded that embryo donation ought not to be treated differently from gamete donation. For a small group of people, the former type of donation offers the only chance to have a child. This group should not be denied the advantages offered to those whose desire for a child can be accommodated simply by the donation of sperm or ova. The fact that both the man and woman are infertile or genetically impaired is, from a moral, ethical, and social perspective, an entirely fortuitous event.

Accordingly, the Commission recommends that, as a matter of general principle, artificial conception technologies, that is, artificial insemination, I.V.F., and *in vivo* fertilization followed by lavage, should continue to be available and accepted as legitimate techniques to be used (except where a fertile and genetically healthy single woman receives treatment) where medically necessary to circumvent the effects of infertility or genetic impairment.

The mere endorsement of the new reproductive technologies does not, of course, ensure their continued use on a stable, legal foundation. As we have seen in chapter 3, the present law deals only inadvertently, if at all, with the many novel issues raised by artificial conception. We stated there that the law must respond positively and unambiguously to the new technologies if they are to flourish on a solid legal footing. Accordingly, the Commission further recommends that the use of the new artificial conception technologies should be subject to the recommendations proposed in subsequent sections of this chapter. These recommendations deal with the critical component parts of a regulatory scheme, from eligibility to participate in an artificial conception programme, to parentage and the status of artificially conceived children, consents, record-keeping, gamete banks, experimentation, and several other vital issues.

As we indicated in chapter 4, the nature of our response to the method of regulation need not necessarily be uniform from issue to issue. Legislation, judicial determination, and the rules and practices of the medical profession may, and will, be used in various ways to deal with particular problems. Nor have we attempted to establish a scheme that would codify all facets of the relatively new, and rapidly developing, medical technologies. We agree in principle with the Warnock Committee's view that there may well be "real dangers in the law intervening too fast and too extensively in areas where there is no clear public consensus".[23]

However, the Commission believes that, in some instances, judgments, based on our perception of sound public policy and law reform, may have to be made even where "there is no clear public consensus". The public may be more or less evenly divided in its views; yet the present law may be unsatisfactory to all parties. To await a consensus may be a luxury that we can ill afford; in the meantime, the uncertain and unsatisfactory state of the law may prejudicially affect all participants in artificial conception services, and particularly their children. In such circumstances, while we must be guided in part by our view of community values, decisions must be taken even though they may not necessarily reflect a clear consensus.

---

[23] Warnock Report, *supra*, note 2, para. 1.9, at 7.

The recommendations that follow reflect, then, our attempt to marry our perception of community values with our perception of sound public policy and progressive law reform. For the most part, the regulatory scheme proposed by the Commission virtually ignores artificial insemination by a husband or by a partner in a nonmarital relationship (A.I.H.). Indeed, unless expressly stated otherwise, we do not deal with artificial insemination where the sperm used is that of the recipient's husband or partner, since generally we do not believe that A.I.H. should be the subject of regulation. Of all the technologies, A.I.H. has the widest acceptance and poses the fewest legal and other problems.

Moreover, unlike I.V.F., A.I.H. does not involve a great expenditure of public funds; nor does it unduly strain the time and resourses of hospitals, physicians, and other scientists. This relatively limited investment of time and money in the case of A.I.H. helps to explain why we believe that, by and large, A.I.H. may be left alone, to be governed by the present law and practice, as amended by those few proposals that we make.

The format of the remaining sections is as follows. First, we shall deal with those issues that are common to all the technologies (again, bearing in mind that A.I.H. is not included unless expressly provided). Secondly, additional issues relating to the fertilized ovum outside the body will be considered. Finally, we shall set forth our proposals for reform in respect of surrogate motherhood.

3. GENERAL RECOMMENDATIONS FOR REFORM

(a) ARTIFICIAL CONCEPTION SERVICES AS THE "PRACTICE OF MEDICINE"

In chapter 3 of this Report,[24] the Commission sought to determine whether the provision of artificial conception services constitutes the "practice of medicine", thereby bringing the procedures under the regulatory purview of the *Health Disciplines Act*[25] and restricting them to persons licensed to practice medicine under Part III of that statute. Although, as we noted, others may be authorized "to perform specified acts in the practice of medicine under the supervision or direction" of a licensed doctor,[26] apart from this exception, engaging in the practice of medicine by unlicensed persons is an offence under the Act.[27]

We need not recanvass the question whether artificial insemination or

---

[24] *Supra*, ch. 3, sec. 2.

[25] R.S.O. 1980, c. 196.

[26] *Ibid.*, s. 50(k).

[27] *Ibid.*, ss. 52 and 67.

I.V.F., or any of the allied procedures, is the practice of medicine under existing law.[28] Rather, our concern here is with the merits and demerits of statutorily declaring artificial conception procedures to be the practice of medicine. Clearly, the attempt to preclude unlicensed persons from performing certain procedures having an obvious medical component serves to promote public health and welfare. The designation of a procedure to be the practice of medicine does not merely permit only licensed doctors to undertake it; it also obliges the College of Physicians and Surgeons of Ontario to regulate the practice[29] and therefore, for example, to "establish, maintain and develop standards of qualification and practice"[30] and of "professional ethics",[31] all in the public interest.[32]

The senior councils of the College have lay representation[33] and, through the regulatory control of the Minister of Health,[34] the College is at least indirectly accountable to the general public. Furthermore, it functions under legislation that can be amended by the provincial Legislature, and regulations passed under the the *Health Disciplines Act* are made by the Council of the College with the approval of the Lieutenant Governor in Council and with prior review by the Minister of Health[35] in order to reflect public perceptions on questions of health. The College has the professional expertise to regulate matters of technical medical detail and, under the Act and regulations, individual medical practitioners may be monitored and disciplined for professional misconduct, and complaints may be made by the public to the College.[36]

But a declaration that a certain procedure is the practice of medicine also has another dimension to it, not related to the quest to promote public health and safety. Such a declaration, by concentrating the provision of the applicable services in the hands of licensed doctors alone, may well result in the inaccessibility of these services to persons who cannot pay for them, particularly where public health insurance funds are unavailable, or who are geographically too distant from a licensed doctor. Accordingly, the matter of designating artificial conception services as the practice of medicine may be somewhat more complicated than would appear at first blush. This issue may be seen to be even more complicated if one adds to the equation the view that the principle of "individual autonomy" mandates an absence of state interference in the process, particularly where A.I.H. is involved.

---

[28] While the complexity of I.V.F. and its dependence on the exercise of medical skills and judgment make it more likely to be considered a medical procedure, the relative simplicity of artificial insemination renders its legal characterization less obvious.

[29] *Health Disciplines Act*, *supra*, note 25, s. 46(2)(a).

[30] *Ibid.*, s. 46(2)(c).

[31] *Ibid.*, s. 46(2)(d).

[32] But see the view of Garrow J.A. in *In re Ontario Medical Act* (1906), 13 O.L.R. 501 (C.A.), at 511-12.

[33] See *Health Disciplines Act*, *supra*, note 25, s. 48(2)(b), respecting the Council of the College. See, also, *ibid.*, s. 54(1)(c) (Executive Committee), s. 55(1)(c) (Registration Committee), s. 57(1)(c) (Complaints Committee), and s. 59(1) (Discipline Committee).

[34] See, for example, *ibid.*, s. 49.

[35] *Ibid.*, s. 50.

[36] See, generally, *supra*, ch. 3, sec. 3(d).

The necessary balancing of interests implicit in the preceding discussion requires us to weigh the need for medical care and supervision against the desire of people to make their own arrangements.

Insofar as the techniques involved in I.V.F. are concerned, the acquisition of ova and the subsequent placement of a fertilized ovum into an appropriately prepared uterus are dependent upon medical skills. The same conclusion applies to the acquisition, by lavage, of ova fertilized *in vivo*. In some cases, where, for example, an ovum is acquired by a surgical procedure and under a general anesthetic, the risks to the patient are clear.

As we have seen in chapter 3, artificial insemination is a simpler procedure than I.V.F. Nevertheless, in the case of artificial insemination, infection and penetration of the cervix by instruments, and injections of semen into the cervix, potentially causing severe shock or death, are very real risks, however infrequently they may arise.

Where donor gametes are considered for use in an artificial conception procedure, different factors weigh in the balance. First, there is the question whether the use of donor gametes is advisable. Before a woman considers the use of donor semen, for example, she should be counselled concerning the prospects, risks, and advantages of conceiving the genetic child of her partner. If he has failed to make her pregnant naturally, due to a low sperm count, for instance, means may be applied to treat him or to accumulate his sperm before insemination in order to increase the chance of pregnancy. Accordingly, unnecessary recourse to donor gametes may be avoided through medical care.

Where the use of donor gametes appears appropriate, the woman or couple involved should be assured of the donor's suitability to serve as such, determined by reference to the donor's genetic fitness and to individual physical characteristics matched to the woman or woman's partner, or both. These matters require competent medical history-taking and assessment.

Therefore, while, for example, the physical application of donated sperm is a relatively simple matter, the range of counselling, donor selection, and instruction of patients that should precede the procedure, and the subsequent follow-up care to ascertain its effectiveness, depend upon medical knowledge and skills. And where donated ova are required, the case for medical management of the procedure is obviously much more clear and convincing.

A review of reports from other jurisdictions reveals a general belief that the treatment of infertility by means of the new reproductive technologies ought to be undertaken only by or under the supervision or direction of a licensed physician.[37] The express or implicit justification for this view relates to the need to protect the public from the risks and dangers that may arise where unqualified persons engage in procedures that only licensed medical doctors have the expertise to practise.

---

[37] See, for example, Warnock Report, *supra*, note 2, para. 3.1, at 15; Queensland Report, *supra*, note 2, at 105 *et seq.*; Law Society of Scotland, *Draft Submission on Government*

The Commission endorses this view, not only insofar as it deals with the prevention, detection, and treatment of health hazards relating to the patient herself, but also insofar as it deals with the prevention of avoidable harm to children artificially conceived with donor gametes.

We believe that, because of the nature of the procedures, the case for declaring I.V.F. and the procedures respecting ovum or embryo donation to be the practice of medicine is very compelling. Admittedly, it is not impossible for properly trained scientists who are not medical doctors to master the techniques involved. Yet, on balance, the Commission does not wish to see such persons engaging in the practice of artificial conception, at least when they have not been authorized to act under the supervision or direction of a licensed physician; however qualified they might be in their own particular field, they may be ill-equipped to prevent, detect, or treat medical complications that may arise during or after the procedure.

The case for declaring artificial insemination to be the practice of medicine is, we recognize, more controversial, given its relative simplicity and its successful performance by laypersons to date. However, we are of the view that the risks to the woman and to the child are significant enough to warrant intervention as a matter of public policy.

For the reasons advanced above, the Commission recommends the enactment of legislation expressly providing that artificial conception procedures, that is, artificial insemination (including A.I.H.), I.V.F., and *in vivo* fertilization followed by lavage, constitute the "practice of medicine" under the *Health Disciplines Act*. Under such legislation, artificial conception procedures could be performed only by licensed members of the College of Physicians and Surgeons of Ontario or by other persons specifically and legally authorized to perform such services under the supervision or direction of a member.[38]

The Commission has also considered the question whether legislation should go further and require physicians to obtain a special licence or to practise in a

---

Inquiry into Human Fertilisation and Embryology (1983) (hereinafter referred to as "Law Society of Scotland Report"), at 6; and Law Reform Commission of Saskatchewan, *Tentative Proposals for a Human Artificial Insemination Act* (1981) (hereinafter called "Law Reform Commission of Saskatchewan Report"), at 1-12, recommendation (3), and Draft Act, ss. 3 and 24.

[38] We have been advised that, in September, 1982, the Advisory Committee on Special Procedures of the College approved the performance of artificial insemination by specially trained registered nurses. However, while nurses are, in fact, performing artificial insemination, discussions apparently are continuing between the College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario concerning whether the practice must be specifically authorized by the Council of the College of Physicians and Surgeons of Ontario, or whether it is a nursing skill that may be regulated by the College of Nurses of Ontario.

specially licensed health facility in order to perform artificial conception procedures, a view espoused in several reports from other jurisdictions.[39] The purpose of this requirement, like the purpose of statutorily declaring artificial conception services to be the practice of medicine, is fundamentally to exercise control and supervision in order to protect the public health and welfare.

Given our preceding recommendation respecting the role of the medical profession in artificial conception, it should be clear that the Commission fully supports the attempt to promote community health standards and to protect recipients and children involved in artificial conception. However, not every measure of control is necessarily in the public interest; there must be a perceived goal that cannot otherwise be realized without such intervention. We do not believe that a further overlay of licensing, involving a new or expanded bureaucratic involvement in health care, is required to protect the community or its constituents. As we have said earlier in this section and in chapter 3, the nature and scope of the *Health Disciplines Act* and the regulations made under it, the monitoring, disciplinary control, and public accountability of the College of Physicians and Surgeons of Ontario, the jurisdiction of the College to establish binding rules or standards in respect of artificial conception practices, the ultimate control by the Ministry of Health, and the professional expertise and ethics of the medical profession itself, offer, along with the further proposals made in this chapter, a sufficient measure of supervision and regulation of artificial conception services in this Province. Accordingly, we are of the view that physicians should not be required to obtain a special licence or to practise in a specially licensed health facility in order to perform artificial conception procedures.

(b) ELIGIBILITY FOR PARTICIPATION IN AN ARTIFICIAL CONCEPTION PROGRAMME

(i) Criteria for Assessment: Marital Status and Other Matters

One of the most controversial issues respecting the new reproductive technologies concerns eligibility to participate in an artificial insemination or I.V.F. programme, and, more specifically, the question of marital status. In the reports canvassed by the Commission, in the submissions made to us, and in the literature, this critical, threshold issue has been hotly and inconclusively debated. The debate has centred on matters of ethics, religion, private morality, public good, and social policy; it has focused on the importance of the family and marriage as the bedrock of society; and it has ultimately concerned itself, as we believe it must, with different perceptions of what constitutes the best interests of children conceived by artificial means.

---

[39] See, for example, Warnock Report, *supra*, note 2, para. 13.7, at 77; Victoria Report on Donor Gametes, *supra*, note 1, paras. 3.40-3.41, at 30, and, from the same Committee, *Interim Report* (1982) (hereinafter referred to as "Victoria Interim Report"), para. 5.8.1, at 21-22; British Medical Association, Working Group on Human In Vitro Fertilisation, "Appendix VI: Interim report on human in vitro fertilisation and embryo replacement and transfer" (1983), 286 Brit. Med. J. 1594 (hereinafter referred to as "B.M.A. Working Group Report"), para. (4), at 1594. However, a system of licensing A.I.D. doctors was rejected in British Medical Association, Board of Science and Education, "Appendix V: Report of Panel on Human Artificial Insemination", Brit. Med. J. Supplement 3, Vol. II, April 7, 1973, para. 24, at 4.

Much of the public discussion of, and antipathy to, artificial reproduction is based on the apprehension that "unsuitable" persons may use the new technologies to become parents. Many who, reluctantly or otherwise, accept or acknowledge that virtually no legal controls can be applied to curb reproduction among "unsuitable" persons who are fertile[40] argue that artificial conception services should not be made available to such persons: in a sense, since the means of control are available in the latter case, such means should therefore be used. Others have rejected this type of intervention in the context of eligibility, stressing the alleged right of individual reproductive autonomy and the conceptual anomaly of controlling parents using artificial conception while ignoring parents who conceive naturally.

The paramountcy of the interests of the artificially conceived child helps us to put the issue of eligibility in what we believe to be its proper, child-oriented perspective, a perspective reinforced by the Terms of Reference of this Report and by the obvious public interest in the welfare of children. Since we are firmly of the opinion that our proposals for reform must be animated by our perception of the best interests of artificially conceived children, it follows that we do not view the matter of eligibility as predominantly or essentially applicant-oriented, pertaining primarily to the gratification of the potential participants. While we have endorsed the role of artificial conception in order to alleviate the effects of infertility or genetic impairment in such persons, this is not tantamount to an unrestricted acceptance of the right of *all* infertile or genetically impaired persons to participate in an artificial conception programme. Artificially conceived children, and the public, would not be well served by such an unfettered right.

The Commission has canvassed this matter generally in chapter 4, rejecting what it called the "private ordering" approach to artificial conception in favour of a modified state regulatory approach. We noted that some persons are emotionally ill-equipped to understand or cope with the unique problems of engaging in an artificial conception programme and of bearing and rearing the resulting child, especially where donor gametes are involved. Our general conclusion that the law must impose a degree of regulation in the unique case of artificial conception — regulation that is neither desirable nor practicable in the case of natural reproduction — is particularly apposite when considering the specific issue of eligibility for participation in an artificial conception programme. It is at this initial juncture that the state is able to intervene in a manner that will ensure, as much as possible, that the future child will be born into, and reared in, a satisfactory home environment. Any subsequent state intervention that might take place — if, for example, the child is declared to be "in need of protection"[41] — is clearly not unimportant, but operates only at a later stage, on an *ad hoc* basis, and in rather extreme cases.

---

[40] See Somerville, "Birth Technology, Parenting and 'Deviance' " (1982), 5 Int. J. Law and Psychiatry 123.

Having concluded, then, that the matter of eligibility must not be left simply to the dictates of persons seeking artificial conception services, it remains for us to set forth the range of alternatives and, finally, the standards or criteria to which we subscribe, bearing in mind that our analysis of the options and our final decision must be viewed from the perspective of the best interests of artificially conceived children.

The Commission recognizes, of course, that what may be called "suitability for parenthood" is an amorphous social and psychological concept, fluctuating from time to time. Yet, notwithstanding the fluidity and ambiguity of the concept, it is noteworthy that most of the reports canvassed by the Commission deal expressly or implicitly with the subject and offer (or, frequently, assume) certain conclusions.[42] The critical issue in respect of "suitability for parenthood" relates to the question whether a participant in an artificial conception procedure must be legally married, or at least living in some sort of stable relationship, or whether she may be single and not involved in any type of union. The question whether marriage ought to be a precondition to eligibility raises, in turn, a further question, dealt with in chapter 3 of this Report, namely, whether legislation imposing such a requirement would, for example, violate the provisions of the *Canadian Charter of Rights and Freedoms*[43] or the Ontario *Human Rights Code, 1981*.[44] We do not intend to review the contending arguments here, except to note that discrimination based on marital status is prohibited. Indeed, it was precisely for this reason — the perceived conflict with provincial human rights legislation if all but married women were precluded from undergoing artificial insemination — that the majority of the Law Reform Commission of Saskatchewan recommended that, for the time being at least, the law should not prescribe criteria for the selection of recipients.[45]

---

[41] See *Child Welfare Act*, R.S.O. 1980, c. 66, Part II. See, also, Part III of the new *Child and Family Services Act, 1984*, S.O. 1984, c. 55. During the final editing of this Report, the *Child and Family Services Act, 1984*, was enacted, to come into force on a day to be named by proclamation of the Lieutenant Governor. While the Report will continue to refer to the *Child Welfare Act*, reference will also be made to the *Child and Family Services Act, 1984*.

[42] In some cases, the discussion involves a more or less general consideration of suitability, drawing on several factors as illustrative of what is meant. For example, a Royal Commission in British Columbia put the issue in this way:

> Who, then, should be eligible for AID? One approach to a decision might be the development of a test of 'ability to nurture', which would involve guidelines describing generally the types of emotional and social variables which seem essential to success in parenting a child. The potential recipient would be evaluated on her ability to meet these guidelines and would not be eliminated from consideration just because of her marital status. This 'ability to nurture' test would include the concepts of guidance and a stable home environment as well as the recipient's ability to provide for the child's needs....
>
> The guidelines, moreover, would also involve an evaluation of the physical and mental health of the potential recipient. It is suggested that an attempt to judge the recipient in terms of her conformity to prevailing mores about marriage and lifestyle should be made in the context of their current state of flux and, more importantly, should concentrate on the conduct of the individual which can be shown to relate quite directly to her ability to nurture. As suggested above, the central concern in evaluating the prospective AID recipient should focus directly (and singularly) on her ability to be a successful parent. It is the potential child's interest which must be paramount in this situation.

British Columbia, Royal Commission on Family and Children's Law, *Ninth Report of the Royal Commission on Family and Children's Law: Artificial Insemination* (1975) (hereinafter referred to as "British Columbia Royal Commission Report"), at 10-11.

Most of the other bodies that have turned their attention to the question of marital status have either emphasized that a two parent family is preferable[46] or have ignored the standing of single women, although the British Columbia Royal Commission on Family and Children's Law would not eliminate anyone from consideration "just because of her marital status",[47] and the Royal College of Obstetricians and Gynaecologists in the United Kingdom would not rule out I.V.F. for single women, notwithstanding its "grave reservations".[48]

With respect to the status of unmarried, cohabiting, couples, most of the legislation described in the Appendix to this Report implicitly countenances access by such persons to artificial conception services, but almost all the legislation actually deals with the question only in the context of the status of the child;[49] access to services is, therefore, assumed. Only the Victoria *Interim Report* appears to have suggested that unmarried couples should be precluded from participation, although, even here, the Report did leave the door open for possible participation in the future.[50] Unfortunately, this critical issue was not canvassed in the later Report.[51] However, it bears mentioning that the Victoria *Infertility (Medical Procedures) Act* 1984, provides, with respect to eligibility, that a married woman includes a woman who is "living with a man as his wife on a *bona fide* domestic basis although not married to him".[52] In addition, it is made clear that a single woman is not eligible for treatment.[53]

---

[43] *Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, which is itself Schedule B of the *Canada Act 1982*, c. 11 (U.K.).

[44] *Human Rights Code, 1981*, S.O. 1981, c. 53.

[45] Law Reform Commission of Saskatchewan Report, *supra*, note 37, at 1-4.

[46] See, for example, Warnock Report, *supra*, note 2, para. 2.11, at 11-12: "... as a general rule it is better for children to be born into a two-parent family, with both father and mother, although we recognize that it is impossible to predict with any certainty how lasting such a relationship will be".

[47] British Columbia Royal Commission Report, *supra*, note 42, at 10.

[48] United Kingdom, Royal College of Obstetricians and Gynaecologists, *Report of the RCOG Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer* (1983) (hereinafter referred to as "RCOG Report"), para. 6.1, at 6. It should also be noted that, under the Victoria *Infertility (Medical Procedures) Act* 1984, No. 10163, I.V.F. may not be performed on single women: see ss. 10(3)(a), 11(3)(a), 12(3)(a), and 13(3)(a). See, also, text accompanying note 53, *infra*.

[49] To be considered *infra*, this ch., sec. 3(d), esp. sec. 3(d)(i).

[50] Victoria Interim Report, *supra*, note 39, para. 5.8.5, at 24.

[51] Victoria Report on Donor Gametes *supra*, note 1.

With respect to whether existing Ontario law might have a bearing on the policy issue whether single women ought to be at least eligible for consideration in an artificial conception programme, one may look, by way of rough analogy, to adoption legislation. Under the *Child Welfare Act*,[54] single persons cannot be considered as adoptive parents except in "special circumstances",[55] such as arise when an orphaned or abandoned child has an unmarried relative who wishes to adopt the child and is otherwise qualified to do so. However, some movement away from this position is reflected in Part VII of the new *Child and Family Services Act, 1984*.[56] This new policy is explained in the background paper prepared by the Ministry of Community and Social Services:[57]

> Aside from a recognition of the changing concepts of marriage and the family, requirements imposed by Ontario's Human Rights Code have contributed to the elimination of the 'special circumstances' qualification for unmarried adoptive applicants. *Hence, single applicants will be eligible for consideration as adoptive parents.* It is, however, anticipated that in most cases adoption practice would continue to reflect a strong preference for a two-parent family based on considerations of the child's best interests.

It should be noted that, in addition to the perceived or possible effect of human rights legislation, the Ministry mentioned "the changing concepts of marriage and the family". While consideration of the best interests of existing children eligible for adoption may not be completely congruent with consideration of the best interests of artificially conceived children, the factors noted in the Ministry statement quoted above are germane to both cases: in adoption and artificial conception, the issue is who should be eligible for consideration as prospective parents.

The Commission is acutely aware of the controversy that surrounds the vital question of eligibility. Indeed, the absence of a clear public consensus on this issue is reflected in the views expressed by individual members of the Commission. However, a majority of the Commission has come to the conclusion that, while participation in an artificial conception programme should not be a right given to every infertile or genetically diseased person or couple wishing to have a child, eligibility for participation should not be restricted to married couples or, indeed, even to couples.

---

[52] *Supra*, note 48, s. 3(2)(a)(i).

[53] *Ibid.*, ss. 10(3)(a), 11(3)(a), 12(3)(a), and 13(3)(a).

[54] *Supra*, note 41.

[55] *Ibid.*, s. 74.

[56] *Supra*, note 41.

[57] Ontario, Ministry of Community and Social Services, *The Child and Family Services Act: Draft legislation and background paper* (1983), at 136 (emphasis added).

As we have said, such a restriction would appear to contravene human rights legislation applicable in this Province. Moreover, any *a priori* exclusions based simply on membership in a particular group (such as married persons) would automatically eliminate from consideration single persons or unmarried couples who, by any standard, would make suitable parents.

A majority of the Commission believes that there are many variables that must be considered, including the home environment, the physical and mental health of the prospective parent or parents, their emotional reaction to artificial conception and its real or potential frustrations, the marital status of the parties and, where married or in a *de facto* relationship, the stability of the union.

Accordingly, a majority of the Commission[58] recommends that stable single women and stable men and women in stable marital or nonmarital unions should be eligible to participate in an artificial conception programme.[59] We wish to emphasize that implementation of this proposal would not entitle any person, whether married or not, to artificial conception services. Rather, the proposal deals first with eligibility, affording equal opportunity to all persons to apply for consideration for services, and, secondly, with their stability, focusing on the human factors involved, and not on the matter of status.

Our proposal is intended, therefore, to permit participation in an artificial conception programme only by those persons who, we believe, are likely to offer a proper home environment for the child. While we have left the door open to single women to apply, we do not envisage either a rash of applications by such women, nor a substantial change in the number of single women artificially inseminated.[60] Indeed, it is our view that, as a general rule, the welfare of children is better served when they are reared in a two parent family. We expect that this belief, which mirrors the perception of most child pyschiatrists, social workers, and other knowledgeable professionals, as well as that of the general community, will continue to be reflected in the practice of most artificial conception practitioners.

In order to ensure that the gravity of the eligibility criteria to be addressed by artificial conception practitioners will be fully appreciated by them, we wish to offer a further proposal. In chapter 4, we considered various institutional means that are available to regulate a particular activity, such as legislation, the courts, or the medical profession itself. In the case of the criteria for determining participation in an artificial conception programme, we have already stated our view that the matter ought not to be left to individual physicians. Accordingly, we recommend that the proposed criteria for participation in an artificial conception programme should be set out in regulations made under the *Health Disciplines Act*.[61]

---

[58] Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from this recommendation: see Vice Chairman's Dissent, at page 287 of this Report.

[59] It bears repeating that most of our proposals, including the one just made, do not apply to artificial insemination where the sperm of the recipient woman's husband or partner is used (A.I.H.): see the discussion near the end of sec. 2 of this chapter.

[60] See *supra*, ch. 2, sec. 3(b)(i).

(ii) The Refusal of Artificial Conception Services: Complaints and Appeals

In a previous section, the Commission recommended that artificial conception services should be confirmed statutorily to be the "practice of medicine". We also recommended that prospective applicants for artificial conception be screened to determine, *inter alia*, their general stability and, where relevant, the stability of their marital or nonmarital union, with a view to assessing the likely home environment of any future child. Accordingly, under our recommendations, the question of access to the new reproductive technologies would have more than a purely medical or clinical dimension; our proposals envisage a type of social and psychological screening of applicants.

The kind of pre-treatment assessment contemplated by the Commission would require physicians, perhaps with assistance from other health care and related professionals, to cover a broad range of issues. While there may be no legally established right to artificially assisted procreation,[62] there is at least a social and moral obligation and, perhaps, a legal right to have an application for reproductive assistance respectfully received, fairly assessed, and equitably resolved. This raises the question whether applicants who have been refused access to services should be afforded special rights of review of, or appeal from, the unfavourable decision. Since, as we have said, the determination will be based upon more than a clinical diagnosis and prognosis, and will include, for example, a social and psychological component, it may be appropriate to provide a second forum where the disappointed applicant may challenge an adverse ruling.

As we have seen, several means already exist to challenge and seek review of decisions made in the practice of medicine.[63] Courts of law tend to be respectful of medical and clinical judgments,[64] but not where negligently made. Where persons or agencies bound by the provisions of the *Canadian Charter of Rights and Freedoms*[65] make decisions that violate its principles, the courts are available to afford appropriate remedies. Moreover, the Ontario Human Rights Commission monitors observance of the *Human Rights Code, 1981*,[66] and, in some cases, recourse may be had to the office of the Ombudsman.[67] Administrative law remedies also may be available in the courts against public health authorities, including hospitals. Furthermore, under the *Health Disciplines Act*,[68] the College of Physicians and Surgeons of Ontario has established a Complaints Committee and a Discipline Committee, and beyond the former exists the Health Disciplines Board to review its decisions. Recourse beyond the Discipline Committee lies to the Divisional Court. The Registrar of the College of Physicians and Surgeons may also investigate a member's conduct with the approval of the Executive Committee. Finally, complaints may be made to the hospital, to its own institutional ombudsman, and to the Ministry of Health.

---

[61] *Supra*, note 25.

[62] See *supra*, ch. 3, sec. 3.

[63] See *supra*, ch. 3, sec. 3(d).

[64] See, generally, *Whitehouse v. Jordan*, [1981] 1 All E.R. 267 (H.L.).

[65] *Supra*, note 43.

[66] *Supra*, note 44.

[67] However, there are limits upon the Ombudsman pursuing issues that may be taken or appealed to the regular courts: see *Ombudsman Act*, R.S.O. 1980, c. 325.

The options open to this rich variety of tribunals, once they have accepted a case and have determined that a complaint of improper conduct is well-founded, will depend upon the jurisdiction specifically given to each of them. However, where a practitioner decides upon ethical or conscientious grounds not to provide artificial conception services, ordinarily it is virtually impossible to compel the practitioner to do so.[69]

The present variety of means for the redress of grievances may, of course, fail to satisfy an individual complainant or may not offer a conveniently available forum or remedy. Nevertheless, the range of accessible paths is extensive and appears to the Commission to be adequate in light of existing experience and what can be anticipated in the foreseeable future. Accordingly, the Commission recommends that no additional or different means of challenge or appeal should be made available to a person who is denied access to artificial conception services.[70]

(c) THE DONATION OF GAMETES

(i) Criteria for Selection of Donors

Where donation is required to produce a pregnancy, the selection of gamete donors is of critical importance to the prospective social parent or parents and to the resulting child. Selection is vital not simply from the perspective of the donor's reproductive history, but also from the standpoint of his or her genetic and general medical status. It is self-evident that a donor who has an infertility problem or who has a harmful transmissible disease should not be used to overcome the infertility problems of others.

At present, the medical profession in Ontario has not developed formal guidelines respecting the selection of gamete donors. Indeed, somewhat different methods appear to be used by different physicians to screen donors.[71] Notwithstanding this variation in practice, however, it must be borne in mind that normal medical procedure clearly necessitates extreme care in the selection process. Moreover, the general law concerning the provision of health care services by physicians and others operates in the same way in the present context as it does in respect of any other facet of medical practice.[72]

---

[68] *Supra*, note 25.

[69] In this connection, see the text following note 63, *supra*, ch. 3, respecting the relevant portion of the Canadian Medical Association's *Code of Ethics*, to which the College of Physicians and Surgeons of Ontario subscribes.

[70] Of the reports canvassed by the Commission, only the British Columbia Royal Commission Report appears to have dealt directly with this question. The Royal Commission recommended that an appeal should lie to a specially constituted tribunal "representative of medicine, social sciences and appropriate agencies of government": *supra*, note 42, at 12, recommendation 5.

Most of the relevant reports that the Commission has reviewed deal with the issue of gamete donor selection in a reasonably predictable manner. For example, concern for the patient and the artificially conceived child is general and has resulted frequently in proposals that would impose quite strict screening procedures on doctors and clinics. Some of the reports mention social and psychological, as well as medical, factors,[73] and some deal with the matching of a donor's physical characteristics with those of the prospective parent or parents.[74]

A recent manifestation of concern respecting the proper screening of donations was the report, in July 1984, that the federal government of Canada was planning to license sperm banks and establish criteria for donors.[75] The nature and scope of such initiatives remain to be seen; they appear not to deal, for example, with ovum donation.

Leaving aside for the moment the issue of any federal standards in the future, there is an obvious temptation to define formally the criteria for donation, for example, by statute or regulation, in order to exclude certain harmful qualities. But, as we indicated in chapter 3,[76] there is another side to the matter that may well invite caution respecting a full codification of standards. It may be impossible or impracticable to legislate specifically what must constitute required medical procedure, particularly since knowledge of genetically transmissible conditions is constantly evolving. Legislative standards that are too detailed may inhibit or limit the sound development of medical criteria and legal responses.

Bearing these matters in mind, the Commission recommends that, subject to the further proposal made below, legislation should remain silent on criteria for the selection of donors. Questions of reproductive history, marital status, and genetic and other medical status should be left to professional standards to be set by the medical profession itself.

---

[71] See discussion *supra*, ch. 2, sec. 3(b)(i).

[72] We shall return to the question of artificial conception and legal liability at a later juncture: see *infra*, this ch., sec. 3(f).

[73] See Health and Welfare Canada Report, *supra*, note 1, at 5 *et seq.*; Victoria Report on Donor Gametes, *supra*, note 1, para. 3.13, at 19; and Queensland Report, *supra*, note 2, at 86, para. (xii).

[74] See Law Reform Commission of Saskatchewan Report, *supra*, note 37, at 1-13, recommendation (5), and British Columbia Royal Commission Report, *supra*, note 42, at 14, recommendation 7.

[75] *The Globe and Mail*, Toronto (July 5, 1984), at 1. This initiative was the result of the Health and Welfare Canada Report, *supra*, note 1.

[76] See *supra*, ch. 3, sec. 4(a).

However, we said that our recommendation is subject to a further proposal. Having regard to federal initiatives respecting the setting of standards for donor selection, at least in the context of licensed sperm banks, and given our belief that such standards should be uniform across Canada, we recommend that there should be consultation between the provincial governments and the federal government so that such uniformity may be furthered.

(ii) Minors as Gamete Donors

In chapter 3 of this Report, the Commission reviewed existing legislation dealing with the donation of gametes by minors.[77] We saw that section 3(1) of the *Human Tissue Gift Act*[78] precludes a minor from serving as a donor of "tissue" for "implantation in the body of another living person". We also concluded that the definition of "tissue" in section 1(c) of the Act likely excludes sperm, but not ova: while sperm are "replaceable by natural processes of repair", ova are finite in number.

We have also seen[79] that section 10 of the *Human Tissue Gift Act* prohibits the buying, selling, or dealing in any "tissue" for a transplant or in any body part "for therapeutic purposes, medical education or scientific research" where valuable consideration passes. However, even assuming that sperm and ova are body parts, the Act does not cover an *inter vivos* gift by any person, arguably even a minor,[80] of sperm or ova for research or experimentation purposes.

The question whether minors should be permitted or, in the case of sperm donors, continue to be permitted, to donate gametes has both a medical and what one might call a broader public policy component, although the two are not unrelated. In terms of the procedure, the donation of sperm raises no medical problems and is not subject to medical risks. However, one of the procedures used for ovum donation, which involves a general anesthetic and surgical laparoscopy, represents the very resort to the bodies of minors that the *Human Tissue Gift Act* is presumably intended to prevent. The other procedure for ovum donation involves the *in vivo* fertilization of a woman's single ovum, after which she is subjected to a lavage or flushing procedure, which is intended to remove the embryo before implantation. While not a surgical operation, this procedure has a different risk factor, since an embryo that is not recovered by flushing may become implanted in the ovum donor's uterus, making her pregnant.[81]

---

[77] See *ibid*.

[78] R.S.O. 1980, c. 210.

[79] *Supra*, ch. 3, sec. 7.

[80] But see Dickens, "Contractual Aspects of Human Medical Experimentation" (1975), 25 U. Toronto L.J. 406, at 416. See, also, s. 4(1) of the *Human Tissue Gift Act* (reproduced *supra*, ch. 3, sec. 7) respecting *post mortem* gifts "for therapeutic purposes, medical education or scientific research".

[81] See *supra*, note 9.

On the other hand, an argument may be made that ovum donation is justifiable where an older, mature minor, aged sixteen or seventeen, is willing to serve, and where her decision is ratified upon independent investigation, for instance, in a family court proceeding, upon a showing of good cause. In special circumstances — where, for example, ethnic matching is desired — a mature minor may be willing and appropriate to serve as a donor.

A more compelling case for a minor consenting to donation of her ovum may arise where her ovum is acquired indirectly as a result of therapeutic surgery, such as a hysterectomy, and she is willing for her ovum to be used in another woman's treatment for infertility rather than be wasted. Of course, it may be that therapeutic removal in the latter case would not constitute the "removal forthwith from [her] body" contemplated by section 3(1) of the *Human Tissue Gift Act*, so that she may be legally able to consent to the use of her ovum in an artificial conception procedure. However, donation even under these conditions may have psychological consequences, which a minor may not anticipate or appreciate.

Surprisingly little attention has been given to the issue of minors as gamete donors. One report in Victoria recommended legislation providing that "it shall be unlawful to recover, or receive, any gametes from a child", that is, an unmarried person under eighteen years of age.[82] This recommendation was followed by legislation to the same effect.[83] In addition, the Queensland Report opposed the use of gametes from minors.[84]

As a matter of public policy, and insofar as ethical or social considerations are concerned, the Commission does not have a general antipathy toward gamete donations by minors. However, we are cognizant of the medical and nonmedical rationale for the proscriptions in the *Human Tissue Gift Act*. The nature of the procedure in the case of sperm donation is not such as to warrant the prohibition of this kind of donation. Whether minors may be suitable as sperm donors is, we believe, a matter of clinical judgment, to be determined according to the standards and principles of professional medical practice. Accordingly, we are of the view that the issue of sperm donation by a minor may be left to the general law, which, as we have seen, permits such donation.

The more critical question, then, is that dealing with ovum donation by minors. In this regard, the Commission is unanimous in respect of the general principle, but divided in respect of whether any exceptions to this principle are justifiable.

The majority of the Commission is of the view, and accordingly recommends, that minors should be prohibited from undergoing any procedure undertaken deliberately to donate ova. The majority believes that the medical and surgical risks involved in a laparoscopy, or, in the case of *in vivo* fertilization and lavage, the risk of pregnancy, are, on balance, sufficient to outweigh any perceived merit or advantage in acquiring such ova. A legally required intervention by a family court judge could, of course, screen unwarranted invasive procedures, but the majority of the Commission stresses that such intervention cannot remove or reduce the risks to the donor. A minority of the Commission, while not taking exception to the prohibition recommended above *as a general rule*, would, however, permit a family court judge to approve a minor's donation, and her consent, where good cause has been shown.

---

[82] See Victoria Report on Donor Gametes, *supra*, note 1, para. 3.12, at 18.

[83] See the Victoria *Infertility (Medical Procedures) Act* 1984, *supra*, note 48, s. 25(1).

[84] Queensland Report, *supra*, note 2, at 86, para. (xi).

Notwithstanding the above views, we do not believe that, so long as they have given their valid and informed consent,[85] minors should be prohibited from donating ova acquired indirectly as a result of therapeutic surgery, such as a hysterectomy. Since the surgery in question must be medically indicated in any event, and since at this stage the extraction of the ovum is not in itself harmful or risky, the medical rationale for precluding donation would not apply. Having regard to this fact and to the purpose served by ovum donation, we do not believe that there is a compelling reason why another woman should not receive the benefit of an ovum donated under these circumstances. We see no value being served by wastage of the ovum.[86]

(iii) Consent of Gamete Donors

The consent issue touched on at the end of the preceding section, in the context of the donation of ova by minors after therapeutic surgery, requires separate treatment in a more general context.

We have seen that the *Human Tissue Gift Act*[87] provisions relating to *inter vivos* gifts apply only to the removal of "tissue", which likely excludes semen but includes ova. Furthermore, the provisions appear to be limited to material that is deliberately removed for the purpose of transplantation. Finally, our earlier discussion respecting whether a person has a claim to ownership of, or control over, severed body parts indicates that this area of the law is unclear and unsatisfactory.[88]

Having regard to the state of the law in this area, the Commission is not disposed to leave matters as they are. In addition to the alternative of requiring a person's express consent to act as a gamete donor, we have considered the alternative of legislation that would provide that an acquired ovum is available for donation unless the "donor" is known to object.[89]

---

[85] See *infra*, the following section.

[86] The question of withdrawal of donations will be dealt with *infra*, this ch., sec. 3(c)(iv).

[87] *Supra*, note 78.

[88] See *supra*, ch. 3, sec. 7. Some courts, however, have recognized the concept of abandonment of the products of conception, such as early stillborn fetuses, where no express directions concerning any disposition have been given. See, generally, Dickens, "The Control of Living Body Materials" (1977), 27 U. Toronto L.J. 142, at 183 *et seq.*, and *Hembree v. Hospital Board of Morgan County*, 300 So. 2d 823 (Ala. Sup. Ct. 1974), where it was held that there is no implied term of a hospital-patient contract that prevents the disposal of the patient's body products without the patient's prior permission.

When considering the use of ova or sperm for artificial conception purposes, we believe it is important to bear in mind that we are not dealing simply with a part of the body, like a bone, the use of which has no, or virtually no, ethical or moral dimension to it. Ova and sperm bear the genetic code of their source; their use involves the perpetuation of a particular person's genetic line. Consequently, while a person's psychological or emotional well-being may well be affected by the uses to which other severed body parts may be put, the nature and extent of a person's reaction is likely to be quantitatively and qualitatively different where gamete donation is involved.

As we indicated in the preceding section, an ovum may be acquired during, for example, a hysterectomy. In this case, and in other analogous cases, the woman might be unaware of the acquisition and future use of the gamete. The option of permitting her ovum to be used in an artificial conception programme, notwithstanding the possible ignorance of the "donor", is, to us, unpalatable. Such a regime places too much store in the actions of the physicians involved, the knowledge of the woman, and her timely intervention. It may even encourage subterfuge, precisely to avoid such intervention.

Given the nature of the material in question — whether it be sperm or ova — and given the emotions involved in its donation, the Commission recommends that legislation should expressly require a donor's free and adequately informed consent as a precondition to the donation or use of his or her gametes.[90] Moreover, for the same reasons, we recommend that, at the time of donation, a donor should be entitled to restrict the use of the donated gamete to a specified purpose. Such a restriction should continue in effect even after the gamete has been used in a fertilization procedure, unless, prior to fertilization, the donor has altered the specified purpose or has indicated that the restriction is no longer to apply.

The proposal concerning the restriction on the use of a donated gamete would, for example, permit one sibling to donate a gamete to another sibling without fear that an embryo produced with the donated gamete may be used by a stranger if not transferred to the recipient for whom it was originally intended. It would also allow a donor with ethical or other qualms respecting a particular use to restrict his donation accordingly.

---

[89] This option would clearly favour potential recipients of the ova of others, and, in one sense, would accord generally with the philosophy evinced in the *Human Tissue Gift Act* respecting *post mortem* gifts for transplantation and other uses of body parts where the deceased has made no express gift. Section 5(2) of the Act provides that "[n]o person shall give a consent ... if he has reason to believe that the person who died or whose death is imminent would have objected thereto".

[90] Few committees have canvassed the matter in any detail. It appears that the requirement of consent may have been taken for granted. See, however, Victoria Report on Donor Gametes, *supra*, note 1, para. 3.25, at 24, and Queensland Report, *supra*, note 2, at 79, para. (c).

We envisage that, where restricted donations are possible, the storage facility will have to devise some method of indicating whether the donation in question is subject to some limitation and, if so, what the limitation entails. As a result, for example, sperm donated exclusively for research purposes[91] could not be used to fertilize an ovum donated exclusively for artificial conception purposes. Or, where an ovum donated exclusively for artificial conception purposes is fertilized by sperm donated generally, for any purpose, the use of the fertilized ovum would have to be governed by the more restrictive use; accordingly, if not used for artificial conception purposes, it could not be used for research.

It is not thought that the matter will, in practice, become particularly complicated; it should be emphasized that the vast majority of donations will be general, without restriction. Moreover, some storage facilities may even preclude any problem from arising by accepting only unrestricted donations.

(iv) Revocation of a Donor's Consent

As we have seen, an adult may consent to the donation of ova, and any person may consent to the donation of semen, for transplantation purposes. In addition, an adult, and perhaps even a minor, may give (but not sell) semen or ova for therapeutic, medical education, or research purposes. Intimately related to the issue of consent to donation is the question whether, and to what extent, a donor may change his mind respecting the donation or the use of the gametes.

By way of analogy, it is clear that, in medical treatment and research, patients and subjects are free, without prejudice and without having to give reasons, to withdraw their consents at any time.[92] Of course, a danger of withdrawal after the donation of gametes for artificial conception purposes is that such action may well inconvenience the practitioner and, particularly, the potential recipient.

There appear to be several alternative approaches to the issue. One option is to provide that, upon donation, donors are deemed to have abandoned control over their donation, as though the donation were a sale of a commodity, with title passing immediately to the purchaser. For example, the Royal College of Obstetricians and Gynaecologists in the United Kingdom has recently recommended that, "[w]hen sperm, ova or embryos are donated the donor should surrender all rights to interest or ownership".[93]

The Commission does not favour this option. We believe that, under such a regime, persons might be dissuaded from making a donation because of the total loss of control that such action would entail. Moreover, we are of the view that, given the nature of the material donated, donors are significant moral actors in a critically important facet of human life. Consequently, we believe that their conscientious concern with the use of their genetic material ought to be fostered, not discouraged by deeming donated gametes to have been abandoned.

---

[91] See *infra*, this ch., sec. 4(e)(i).

[92] See Annas *et al.*, *Informed Consent to Human Experimentation: The Subject's Dilemma* (1977).

[93] RCOG Report, *supra*, note 48, para. 14.4.1., at 16. See, also, *ibid.*, para. 5.3, at 5. However, the Report also proposed that "[s]tored semen (other than that produced for donor purposes) remains the property of the man until he requests its destruction": *ibid.*, para. 14.4.3, at 16.

Indeed, the Commission rejects in principle any alternative that precludes donors from exercising a reasonable degree of control over their gametes. Accordingly, we recommend that, after donation, but prior to the use of their gametes in a fertilization procedure, donors should be entitled to require their donation either to be wasted or returned to them, so that the gametes may not be used for artificial conception, research, or any other purpose. As we indicated in the preceding section of this chapter, it would also be possible for a donor, prior to fertilization, to exercise his or her right to restrict the use of the donation to a specified purpose or to indicate that a previously imposed restriction is no longer to apply.[94] We further recommend that a donor's consent given at the time of donation should remain of legal effect until withdrawn or otherwise altered, as proposed above and in the preceding section, so that a fresh consent should not be required each time the gametes are used. Consequently, it is for the donor to take the initiative to express and give effect to any subsequently formed different intention. To provide otherwise would be to create, as a matter of practice, an unworkable scheme. So long as the consent is free and adequately informed, no prejudice will result to donors.

(v) Payments to Donors

We noted earlier in this chapter that section 10 of the *Human Tissue Gift Act*[95] prohibits the buying, selling, or dealing in tissue or body parts for valuable consideration. The obvious purpose of this provision is to prevent a commercial market in human body materials, except "blood or a blood constituent".[96] However, it bears noting that sperm donors are, in fact, routinely paid, presumably for the personal service of supplying sperm, rather than for the sperm itself, as though it were a commodity. Given this presumed legal basis of payment, sale of goods and consumer protection questions concerning, for example, whether the donor gives implied undertakings of quality and fitness for purpose, tend not to arise.[97]

---

[94] While the topic has been considered expressly in few cases, where it has been dealt with the donor's option appears to be limited to withdrawal of donations. See, for example, Victoria Report on Donor Gametes, *supra*, note 1, para. 3.17, at 21, and Queensland Report, *supra*, note 2, at 86, para. (xv). In the Victoria *Infertility (Medical Procedures) Act* 1984, *supra*, note 48, s. 15(1), upon a withdrawal of consent the gametes must be destroyed unless the donor has consented to the use of the gametes in another I.V.F. procedure.

[95] *Supra*, note 78.

[96] We leave aside here the question whether providing A.I.D. to a healthy woman is "for therapeutic purposes", within the meaning of s. 10, since only her husband may have a medical or genetic obstacle to achieving natural insemination: see Dickens, *Medico-Legal Aspects of Family Law* (1979), at 16-17.

The concept of a payment is divisible into compensation for inconvenience and expenses incurred — which, regarding sperm banks run on a noncommercial basis, might represent operating costs — and reward beyond such compensation, representing a profit margin. An analogy between donation of sperm and donation of blood for transfusion is not exact for a number of reasons, but experience indicates that inducing blood donation by the offering of a reward may cause donors to suppress information and disguise their reasons for donation, thus rendering them undesirable as donors.[98]

Despite evidence that encouraging blood donations by the offer of a reward may be undesirable, we have seen that the *Human Tissue Gift Act* does permit payment of those who donate blood or a blood constituent. Although reliance is placed overwhelmingly upon voluntary donation, it is recognized that it may be proper to pay donors of, for example, a particularly rare blood type, and to allow commercial plasmapheresis centres to operate. Payments are permitted because of the public interest in the availability of adequate supplies of transfusible blood. The question is, then, whether the same public interest exists with respect to the availability of gametes for artificial conception.

Reports and legislation from other jurisdictions manifest a general antipathy to payments for the gametes themselves (that is, payments representing a profit), but would countenance payments for expenses, such as travel, medical, and other costs.[99] In some cases, reports have gone further to recommend payment for "time"[100] or "inconvenience",[101] a rather different category than out-of-pocket expenses. Other reports have gone even further, and have proposed that payments be made to compensate for lost wages or revenue.[102] Finally, one report recommended generally that only reasonable expenses should be given.[103]

In light of the Commission's general views on the ethical, moral, and social acceptability of artificial conception, it should be evident that we believe that there is a public interest in the availability of suitably screened gametes for such a purpose. However, we are also of the opinion that the need for a sound family history, and for information concerning whether a donor has contracted a sexually transmitted disease between the initial genetic screening and the donation, compels the conclusion that donors should not be induced to donate gametes by the lure of a reward, lest they suppress important information about themselves. The risk of such suppression, and its cost to those upon whom the burden will fall, outweigh any benefit achieved by permitting unrestricted payments.

---

[97] This matter is considered *infra*, this ch., sec. 3(f)(ii).

[98] See Titmuss, *The Gift Relationship* (1970).

[99] See, for example, Victoria Report on Donor Gametes, *supra*, note 1, para. 3.11, at 18; British Columbia Royal Commission Report, *supra*, note 42, at 23; Queensland Report, *supra*, note 2, at 110-11; The American Fertility Society, *Report of the Ad Hoc Committee on Artificial Insemination* (1980) (hereinafter referred to as "American Fertility Society Report"), para. 12, at 5; and Warnock Report, *supra*, note 2, para. 4.27, at 28. See, also, the Victoria *Infertility (Medical Procedures) Act* 1984, *supra*, note 48, ss. 11(6), 12(6), and 13(7).

[100] See British Columbia Royal Commission Report, *supra*, note 42, at 23.

[101] See American Fertility Society Report, *supra*, note 99, para. 12, at 5.

[102] See British Columbia Royal Commission Report, *supra*, note 42, at 23.

[103] See RCOG Report, *supra*, note 48, para. 14.4.1, at 16.

Accordingly, the Commission recommends that individual donors of sperm should be allowed to be paid their reasonable expenses. These should be based roughly upon the time and inconvenience involved in the initial screening with a view to recruitment into donor programmes, and the periodic follow-up checking of those who remain active donors. However, payment for "discomfort" should not be available. The sum paid should not be so great as to be an incentive to deceive, nor so great as unduly to burden a clinic having to pay for the cost of applicants it rejects. In Ontario, existing payments tend to fall within the $25-$50 range which, without proposing a definite tariff, the Commission considers acceptable.

It is considered that the same principles should be applied to ovum donors, although payments may prove to be greater where ovum recovery involves invasive procedures, such as laparoscopy, or where a woman's naturally released ovum is recovered nonsurgically, by means of *in vivo* fertilization and lavage. Similarly, long term treatment for the multiple acquisition of ova, induced by superovulation, may justify higher payment, which would be acceptable provided that it conformed to the principle of payment only for reasonably incurred expenses.

(vi) Frequency of Use of Donors

Some A.I.D. practitioners impose limits upon how frequently donations from an individual donor may be employed. Either the number of successful pregnancies or the number of donations may be used to measure and limit frequency of use. The reason for this restriction is to reduce the possibility that resultant offspring of different sexes, unaware of their common genetic origin, might meet, marry, and have children in a relationship that would be biologically, although not legally,[104] incestuous. Although the statistical likelihood of inadvertent incestuous unions is low in large population centres and ought, therefore, not to be exaggerated, limiting the use of individual donors may be a sensible precaution where, for example, a doctor practises in a small community or within a relatively small and cohesive ethnic group. An advantage of acquiring sperm from a sperm bank is that the gametes from an individual donor can be distributed over a wide geographical area in order to reduce the possibility of subsequent incestuous unions.[105]

---

[104] Under the *Criminal Code*, R.S.C. 1970, c. C-34, s. 150, the crime of incest is committed only where voluntary sexual intercourse is performed with a person known to be within a prohibited relationship.

[105] Gamete banks are dealt with *infra*, this ch., sec. 3(c)(vii).

In order to prevent the possibility of incest, several reports on artificial conception have recommended limiting the frequency of use of donors. The British Columbia Royal Commission Report, the Health and Welfare Canada Report, the American Fertility Society Report, and the Warnock Report all focus on restricting the number of successful pregnancies.[106]

Notwithstanding the rationale for these proposals, there are certain practical difficulties with them. Legislating against the use of a donor beyond a specified number of occasions would necessitate extensive monitoring and checking, not only of records, but also of the identities of named donors. Furthermore, it would require comparisons of the records of donors of individual practitioners and clinics with those of other practitioners and clinics, since a donor who had exhausted his utility with one practitioner might apply to donate to another.[107]

Legislation also may not be appropriate in that it would interfere unduly with clinical judgment respecting the use of an appropriate available donor. Legislation might limit the means of a woman, successfully inseminated and bearing a child through an individual donor, to seek further resort to him so that she may have a family of children who are full siblings.

Practical limits on the use of donors may arise as a result of our proposal to restrict financial payments to reasonable expenses, thereby precluding donation for a profit.[108] Moreover, experience shows that donors tend to serve as such for only limited times in their lives and that most donors are aware, or have been warned, of the potential problems associated with multiple donations and act accordingly. Finally, doctors, as well, are conscientious in attempting to preclude the scenarios described above.

As we stated earlier in passing, while we recognize the rationale for limiting donations from individual donors, we do not believe that the actual or potential magnitude of the problem warrants intervention. In those cases where caution is appropriate, we are of the view that practitioners are, and will continue to be, assiduous in avoiding the multiple use of the same donor.

Sound law reform in this area must reflect not only theoretical problems that might arise, but also the likely extent of such problems and the practicalities of remedying them. Having regard to these factors, the Commission recommends, on balance, that the frequency of employment of individual gamete donors is a matter that should properly be left to the professional judgment and ethics of medical practitioners and to the preference of participants in artificial conception programmes.

---

[106] British Columbia Royal Commission Report, *supra*, note 42, at 19, recommendation 12 (6 pregnancies); Health and Welfare Canada Report, *supra*, note 1, at xiv, recommendation 2.4 (no number proposed); American Fertility Society Report, *supra*, note 99, para. 9A, at 5 (15 pregnancies); and Warnock Report, *supra*, note 2, para. 4.26, at 26-27 (10 children).

[107] With respect to the maintenance of a "central" register in the context of artificial conception services, see, for example, Victoria Report on Donor Gametes, *supra*, note 1, para. 3.32, at 27, and the Victoria *Infertility (Medical Procedures) Act* 1984, *supra*, note 48, s. 22.

[108] See *supra*, this ch., sec. 3(c)(v).

(vii) Sperm, Ova, and Embryo Banks

As we have seen, section 10 of the *Human Tissue Gift Act*[109] prohibits the buying, selling, or dealing in any tissue or body part for valuable consideration. Consequently, gamete banks cannot operate in Ontario on a commercial basis, whether for profit or not. At present, sperm banks exist in some Ontario hospitals, and commercial sperm banks operate, for example, in the United States. While ova, unlike sperm, cannot now be stored for future use,[110] it is not unreasonable to expect that technological advances will overcome present difficulties. Embryos, however, may be preserved for subsequent transfer.[111]

The question arises, then, whether commercial gamete banks — that is, banks that buy and sell gametes and embryos — should be permitted to operate in the Province and, if so, on what basis. We should mention here that recent federal proposals to license sperm banks[112] would deal, at least in part, with standards of operation, but would not extend to the actual authorization of commercial operation as such.

While the characterization of a gamete bank as "commercial" does not necessarily involve an element of profit — it could simply refer to the receipt of payments in order to recover reasonable operating expenses, for example — the buying and selling of gametes or, one might say, the commercialization of this aspect of human reproduction, may appear rather offensive at first blush. On reflection, however, it may be less unorthodox than it seems and may, in fact, be an ethically and socially acceptable outgrowth of the acceptance of artificial conception itself.

In the first place, the purchase and sale of health care services and medical necessities is hardly novel. As we have seen, section 10 of the *Human Tissue Gift Act* expressly legitimizes the purchase and sale of "blood or a blood constituent", presumably because it is in the public interest to stockpile supplies of blood and to encourage people to contribute to them. Moreover, many means of achieving natural reproduction — the surgical treatment of reproductive impairments, for example — depend upon the existence of paid services, where profit is involved. Finally, once it is accepted that individual gamete donors may receive payment for their reasonable expenses where there is a direct donation,[113] it may be anomalous to proscribe similar payment to agencies that recruit and screen donors and preserve sperm by freezing.

---

[109] *Supra*, note 78.

[110] See Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on the Disposition of Embryos Produced by In Vitro Fertilization* (1984) (hereinafter referred to as "Victoria Report on Embryos"), paras. 1.6.3-1.6.5, at 9-10.

[111] See *ibid.*, paras. 1.7-1.8, at 10-11.

[112] See *supra*, this ch., note 75 and accompanying text.

[113] See *supra*, this ch., sec. 3(c)(v).

We do not wish to labour the point. Suffice it to recognize that socially useful (indeed necessary) and ethically acceptable health care services and products have always been provided at a cost, and frequently at a profit.

Secondly, it must be borne in mind that the Commission finds artificial conception ethically, morally, and socially acceptable in principle. Accordingly, any suggested restriction on the availability of the necessary elements of an artificial conception programme must be scrutinized very carefully; it would be futile and frustrating to give with one hand, only to take with the other. It is from this perspective that we view the question of so-called commercial gamete banks.

Certain A.I.D. practitioners in Ontario now use commercial sperm banks operating in the United States. Presumably, they find their recruiting and screening services reliable; moreover, they enjoy the advantage of ordering sperm according to fairly detailed specifications. Commercial banks also aid anonymity where sperm is sought from an ethnically identified donor not commonly found in a community from which fresh sperm would come. They also have the advantage of distributing an individual donor's sperm over a wide geographical area, thereby reducing the possibility of the donor's offspring of different sexes meeting and marrying.

In the main, there seems to be general, although not unanimous, agreement that gamete banks serve a useful purpose and should be allowed to operate under licence from the appropriate public authority.[114] We have come to the conclusion that, given the need for both gametes and public accountability, an appropriately operated licensing system would provide for the reasonable availability of gametes of assured quality, while at the same time precluding offensively aggressive marketing enterprises seeking only profits by means of the recruitment of donors and the supply of gametes.

Accordingly, we recommend that gamete banks, that is, banks that buy and sell sperm, ova,[115] and embryos, should be permitted to operate on a commercial basis. However, they should be allowed to operate only under licence and under stringent regulations setting standards of operation, with respect, for example, to payment by users to defray reasonable costs and, perhaps, to provide a reasonable profit. Gamete banks should operate subject to public accountability or under the auspices of a public organization, preferably on the model of the Canadian Red Cross Society blood donor clinics.

---

[114] See British Columbia Royal Commission Report, *supra*, note 42, at 32-33; Queensland Report, *supra*, note 2, at 110-11; and Warnock Report, *supra*, note 2, para. 13.13, at 79. One Report canvassed by the Commission would put a moratorium on the establishment of banks outside the jurisdiction of a university or other publicly owned agency: Health and Welfare Canada Report, *supra*, note 1, at 16 and xiv, recommendation 2.5. Another Report recommended that "no hospital authorised to conduct a cryopreservation programme [should] maintain a bank or store of large numbers of frozen embryos from which embryos may be disposed of as the hospital thinks fit": Victoria Report on Embryos, *supra*, note 110, para. 2.3, at 24-25.

[115] We include ova here in anticipation of the future possibility of storing such gametes.

Earlier, we noted the recent federal initiatives respecting the licensing of sperm banks. Having regard to these initiatives, and to the proposal we have already made in this connection,[116] we recommend further that there should be consultation between the provincial governments and the federal government so that the goal of uniformity of standards across Canada may be furthered.

One final matter bears on the topic of gamete banks. The Commission has endorsed the operation and licensing of gamete banks because it is of the view that their existence is ethically and socially acceptable and that they facilitate the provision of necessary and desirable services to the infertile and the genetically impaired. However, we have also made recommendations that would, in effect, place artificial conception services under the supervision of licensed doctors.[117] Accordingly, we wish to restrict access to gamete banks. To this end, we recommend that licensed gamete banks should be prohibited from supplying gametes or embryos to any person or agency other than a licensed physician, a hospital or other approved health care facility, or another licensed sperm bank.

(viii) Importation of Gametes and Embryos from Outside Ontario

Related to the issue of commercial gamete banks is the question of the importation of gametes (including embryos) into Ontario from outside the Province. As we said in chapter 3,[118] there may well be a constitutional prohibition against any attempt to bar, or even restrict, such importation, given the jurisdiction of the federal Parliament over the "regulation of trade and commerce".[119] In addition, the *Canadian Charter of Rights and Freedoms*[120] may affect any attempted prohibition of transactions within Canada.

However, these real or potential constitutional limitations may not imperil provincial legislation dealing with the use and quality of imported gametes. Just as in the case of gamete banks, the Commission is concerned about the danger of offensive commercialization of the gamete market and the loss of quality control over gametes used in Ontario. Recourse to out-of-Province suppliers should not become a means of escaping quality standards prevailing in Ontario.

Having regard to our earlier proposal respecting the establishment and regulation of gamete banks, and its underlying rationale, we do not believe that a compelling case can be made out for the prohibition of the importation of gametes from outside Ontario. Aside from any constitutional impediment to such action, we believe that there are sound reasons why prohibition is not a satisfactory option. In some cases, members of a distinctive ethnic or other group may not be able to find suitable donors in the Province. In other cases, the matching of a donor's characteristics to those of the recipient and his or her spouse or partner may be facilitated if Ontario physicians were able to import gametes from the United States or elsewhere. We see no reason to preclude such flexibility, so long as quality control is not sacrificed in the process. The critical question should always be the quality of the gametes, tested mainly by the medical suitability of the donor rather than by the geographic source of the gametes.

---

[116] See *supra*, this ch., sec. 3(c)(ii).

[117] See *supra*, this ch., sec. 3(a).

[118] See *supra*, ch. 3, sec. 4(b).

[119] *Constitution Act, 1867*, 30-31 Vic., c. 3 (U.K.), s. 91.2.

[120] *Supra*, note 43.

Accordingly, the Commission recommends that the use of gametes and embryos imported from outside Ontario should be permitted but should conform to the standards set in respect of gamete banks operating in the Province. Having regard to the previously described federal initiatives in this general area, we further recommend that, with regard to importation, there should be consultation between the provincial governments and the federal government to ensure that uniform standards are established for the whole of Canada.

(d) STATUS OF ARTIFICIALLY CONCEIVED CHILDREN: PARENTAGE, BIRTH REGISTRATION, AND INHERITANCE RIGHTS

As we have emphasized on numerous occasions throughout this Report, the Terms of Reference of the Commission's study direct us to pay particular attention to the best interests of the artificially conceived child. Central to the welfare of such a child and to its "identity" is the child's secure legal, social, and emotional status within its family and in the wider community. We shall examine these matters, and offer recommendations for reform, in the sections that follow.

(i) Parentage of Artificially Conceived Children

a. Legal Status of Social Parents and Gamete Donors

In chapter 3, we considered the question of the legal status of the artificially conceived child.[121] We need not repeat that discussion here, beyond providing briefly some background to our proposals for reform. We indicated earlier that the two major pieces of legislation in the area — the *Children's Law Reform Act*[122] and the *Vital Statistics Act*[123] — frequently accommodate neither the reasonable expectations of the parties nor the welfare of artificially conceived children. For example, while legislation does permit a married, cohabiting couple to make use of a presumption that the husband is the father of a child conceived with donor sperm,[124] and requires the child to be registered accordingly,[125] the presumption of paternity is rebuttable by "[a]ny person having an interest",[126] including, for example, the sperm donor. Moreover, an infertile husband seeking to regularize his relationship with the child would have to found his application for a declaration of paternity under the *Children's Law Reform Act* on a lie, since he is not, in fact, the natural father. Finally, where the recipient woman is in an unmarried relationship, the legislation cannot be used to regularize the birth of an A.I.D. child: her male partner could not be recorded as the child's father unless he were to declare falsely that he was the father.

---

[121] *Supra*, ch. 3, sec. 5.

[122] R.S.O. 1980, c. 68.

[123] R.S.O. 1980, c. 524.

The question of status and parentage bears directly on a wide spectrum of legal rights and obligations respecting all parties involved, including support rights under the *Family Law Reform Act*[127] and succession rights under the *Succession Law Reform Act.*[128] And, in turn, these legal consequences affect the social and psychological stability of the child, both in its family and in society.

The potential for legal assaults on the relationship between the social parents and the artificially conceived child, and the need to conceal the biological truth in order to regularize such a relationship are, we have said, both unwholesome and unacceptable, for they run counter to the best interests of all concerned, and particularly the child. We are reinforced in this strongly held conclusion by the unanimous support for it in the reports canvassed by the Commission. With only minor deviations, the committees and bodies that have examined the question of parentage and status have recommended in principle that, where artificial conception using donor sperm has taken place with the consent of the woman and her spouse, the latter should be deemed in law to be the father for all purposes, and the donor should have no legal connection to the resulting child. Legislation has followed suit in several jurisdictions as well.[129]

Our conclusion, and the conclusions of others just noted, that the present state of affairs is not satisfactory has not been arrived at simply on the basis of legal theory. We are well aware that, despite manifold legal problems in this area, the practical results in the majority of cases (certainly of A.I.D.) do reflect the intentions of the parties and do manage, more or less, to accommodate the best interests of the children. At least where the participants are a married, cohabiting man and woman, and where, as is the usual case, the donor is anonymous, the social fact is more telling than the potentially unstable legal situation might indicate.

---

[124] *Children's Law Reform Act*, *supra*, note 122, s. 8(1)1.

[125] *Vital Statistics Act*, *supra*, note 123, s. 6(4).

[126] *Children's Law Reform Act*, *supra*, note 122, s. 4(1).

[127] R.S.O. 1980, c. 152.

[128] R.S.O. 1970, c. 488.

[129] See, for example, legislation based on the United States Uniform Parentage Act: National Conference of Commissioners on Uniform State Laws, Uniform Parentage Act, Uniform Laws Annotated, Vol. 9A, §5. See, also, Part II of the Victoria *Status of Children (Amendment) Act* 1984, No. 10069. This legislation is discussed in sec. 3 of the Appendix to this Report.

However, as we have said, existing law achieves the parties' reasonable and justifiable intentions on a very fragile basis. We believe that the challenge and role of the law in this area is to remove what uncertainty now exists, to regularize family relationships that the law does not now, but should, expressly recognize, and to exclude gamete donors who are otherwise strangers to the new relationship. Accordingly, the Commission recommends that, for all purposes, a woman bearing a child through artificial conception in order to rear it[130] should be conclusively deemed to be the child's legal mother, and that the woman's husband or male partner[131] who consents to the initiation of the artificial conception procedure or procedures should be conclusively deemed to be the child's legal father. A donor of sperm or an ovum should have no legal relationship to the child arising from the fact of donation; in other words, a donor should have no parental rights or duties regarding the artificially conceived child.

It will be noted that, under our proposals, only a consenting husband or partner would be deemed to be the natural father of a child conceived artificially with donor gametes. We recognize that this means that, where no consent is given to the artificial conception procedure, but where the woman undergoes the procedure in any event, the resulting child would not have a legal father: in these relatively rare cases, our previous proposals would preclude the non-consenting spouse or partner from being deemed to be the legal father, and would also eliminate the donor. However, we believe that, in such a case, it would be exceedingly unfair to place on the spouse or partner the legal burdens that he clearly did not wish to assume.[132]

b. The Nature and Form of a Husband's or Partner's Consent

The issue of the nature and form of a husband's or partner's consent in the context of the child's status and paternity has been dealt with by several bodies outside Ontario, where a determination had to be made concerning the circumstances in which a husband or partner would be deemed in law to be the father of a child with which he had no biological connection. The most comprehensive discussion of the consent question appears in the working paper[133] and report[134] on illegitimacy published by the English Law Commission. The Law Commission canvassed two approaches, one requiring a writing in a prescribed form and perhaps formally witnessed,[135] the second involving a presumption of consent.[136] The first alternative was said to give rise to timing problems. The Law Commission preferred that consent should be given before the treatment in question was commenced, but stated that, while this last option "is clearly desirable in the interests of fairness to the husband ... we doubt if it is sufficiently important in the interests of society as a whole to justify elevating it into a positive rule of law".[137]

---

[130] With respect to surrogate motherhood arrangements, where the birth mother does not intend to rear the child, see *infra*, this ch., sec. 5.

[131] With respect to the eligibility of unmarried couples for artificial conception services, see *supra*, this ch., sec. 3(b)(i).

[132] It does bear mentioning here that, while a non-consenting husband or partner would not be deemed to be the legal father of the artificially conceived child, he would owe the child a support obligation under s. 16 of the *Family Law Reform Act*, *supra*, note 127, where he "has demonstrated a settled intention to treat [the] ... child [as a child] of his ... family". (See the definition of "child", *ibid*., s. 1(a).) Moreover, such a child may apply for a support order under the dependants' relief provisions of the *Succession Law Reform Act*, *supra*, note 128, where the deceased husband or partner has not made adequate provision for the proper support of the child.

Instead, the second approach was taken, an approach subsequently endorsed by the Law Society of Scotland.[138] The Law Commission said that, for the purpose of status and paternity, "[i]t would be presumed that the husband had consented unless he (or anyone else with a sufficient interest) satisfied the court that he had not done so".[139]

The Commission believes that, if some manifestation of prior consent were required in order to deem the husband or partner to be the child's natural father, the failure to comply with such a requirement would clearly be highly prejudicial to the resulting child: the child would be rendered legally fatherless, notwithstanding the fact that, while not following the requirements to the letter, the husband or partner might, in fact, have agreed to the procedure. The potential for injustice would be even greater where a more formal, written consent requirement was in place. Such a requirement might be impossible to fulfil where, for example, the husband or partner might be reached in time only by telephone or telegraph.

We cannot think of a more unpalatable regime than one in which the child's legal status is made dependent upon some affirmative, mandatory manifestation of consent by the mother's spouse or partner, and particularly upon a formal, written consent procedure, prior to the commencement of treatment. Accordingly, we recommend that the consent of the husband or partner should be presumed as a matter of law. However, this presumption should be rebuttable at his instance or at the instance of another person with a legitimate interest. In the latter connection, for example, a beneficiary under the will of the husband or partner may wish to adduce evidence that the husband or partner did not consent to the artificial conception procedure, where a successful rebuttal of the presumption would augment the beneficiary's share of the deceased's estate.

---

[133] The Law Commission, *Family Law — Illegitimacy*, Working Paper No. 74 (1979) (hereinafter referred to as "Law Comm. W.P.").

[134] The Law Commission, *Family Law — Illegitimacy*, Law Com. No. 118 (1982) (hereinafter referred to as "Law Comm. Report").

[135] *Ibid.*, para. 12.14, at 174.

[136] *Ibid.*, para. 12.16, at 175. See, also, Law Comm. W.P., *supra*, note 133, para. 10.16, at 140.

[137] Law Comm. Report, *supra*, note 134, para. 12.15, at 175.

[138] Law Society of Scotland Report, *supra*, note 37, at 7. See, also, *Children's Act*, S.Y.T. 1984, c. 2, s. 14 ("consents in advance"); United States Uniform Parentage Act, *supra*, note 129, §5(a) (consent in writing and signed by husband and wife); Victoria *Status of Children Act* 1974, No. 8602, ss. 10C-10E, enacted by *Status of Children (Amendment) Act* 1984, *supra*, note 129 (consent rebuttably presumed); the proposed South Australia *Family Relationships Act Amendment Act, 1984* (Bill No. 4), s. 6, adding (*inter alia*) s. 10d(2) to the *Family Relationships Act, 1975*, No. 115; and the American legislation discussed in sec. 3(c)(i)b(2) of the Appendix to this Report.

[139] Law Comm. Report, *supra*, note 134, para. 12.16, at 175 (footnote reference deleted).

As a result of our proposal, the onus of proof would be on the person attempting to rebut the presumption. The court hearing the matter would be able to draw appropriate inferences from the man's conduct, for example, without being constrained by particular forms of expression of consent or dissent.

(ii) Retroactive Recognition of Parentage

The critical legal, social, and psychological importance of the issue of status and parentage has been underscored in the preceding section. Indeed, the Commission is so firmly committed to its proposal to regularize the status of artificially conceived children that it believes that it is justifiable and desirable to extend it to existing children.

Accordingly, having regard to the recommendations made above, and in conformity with at least the *de facto* status of many existing artificially conceived children, we recommend that the proposed legislation respecting the status and legal parentage of such children should be retroactive in effect. Such a provision would relieve past gamete donors of parental rights and duties, and would regularize the status of husbands and male partners who hitherto have treated the children as if they had been conceived naturally within marital or nonmarital unions.

(iii) Registration of Birth

a. Where Donor Gametes are Used

Intimately related to the preceding issue of status and parentage is the question of birth registration, the documentary manifestation of these two legal concepts. In chapter 3, the Commission considered in some detail the law and practice respecting the registration of births under the *Vital Statistics Act.*[140] The system of birth registration contained in this Act serves as a record of the circumstances of birth and, as well, provides one means by which the parentage of children is presumptively established.

It will be recalled that, in the case of married, cohabiting persons, the child must be given the surname of the husband and the particulars of the husband must be given as those of the father;[141] but, as we have seen, the presumption that the child is a child of the couple is rebuttable. Where an unmarried woman gives birth to a child, no particulars of the father must be given unless she and a male who acknowledges himself to be the father jointly request that his particulars and surname be given.[142]

---

[140] *Supra*, note 123.

[141] *Ibid.*, s. 6(4).

We have noted already that, in the context of artificial conception, the continuing efficacy of these presumptions is dependent, in one sense, on the provision of false information and on the anonymity of the gamete donor. These factors help to preserve the register of births as a social, rather than a true biological, record of parentage, frequently conforming to the reasonable intentions of the parties and furthering the well-being of the artificially conceived child.

As we have said before, this haphazardly effective system does not conform to modern perceptions of status and paternity. Consistent with our views on these two matters, the Commission recommends that, in the case of artificial conception with donor gametes, the woman who bears and intends to rear[143] the child should be registered as the child's mother, and the mother's spouse or partner who, under our previous proposals,[144] is deemed to be the legal father, should be registered as the child's father.[145] The gamete donor should not be named in the register of births, nor should the fact of artificial conception appear in the register.

b. Posthumous Artificial Conception, Where No Donor Gametes are Used

Section 6(4) of the *Vital Statistics Act* is, as we have seen, a provision that requires the registration of the husband's surname, and the giving of the husband's particulars as those of the father, where a child is born to a "married woman". Consequently, where a widow gives birth to a child conceived posthumously by means of her deceased husband's preserved sperm, the widow would not be able, at least as a matter of law, to use section 6(4) of the Act. However, where the child is born within 300 days of the husband's death, the widow may ultimately gain registration showing her deceased husband's surname and particulars by utilizing the rather circuitous path of applying for, and obtaining, a declaration that her husband is the legal father[146] (having regard to the statutory presumption[147]), and then seeking the desired registration from the Registrar General.[148]

---

[142] *Ibid.*, s. 6(7) and (8).

[143] The case of surrogate motherhood is examined elsewhere: see *infra*, this ch., sec. 5.

[144] See *supra*, this ch., sec. 3(d)(i).

[145] Accordingly, having regard to our earlier proposals (see *ibid.*), the husband or partner may contest the registration — indeed, his presumed paternity — by proving that he did not consent to the procedure.

[146] *Children's Law Reform Act*, *supra*, note 122, s. 4(1).

[147] *Ibid.*, s. 8(1)2.

[148] *Ibid.*, s. 16.

Under the procedure just described, time is obviously of the essence: a delay in posthumous A.I.H. would mean that the child could be born outside the 300 day period, in which case no statutory presumption of paternity would arise; under these circumstances, because the husband has died, no application could be made for a paternity declaration.[149]

The status of a child conceived posthumously by means of the sperm of an unmarried mother's deceased partner is also precarious. Again, there is a limited 300 day statutory presumption of paternity.[150] In addition, the *Children's Law Reform Act* refers, somewhat ambiguously, to a birth occurring within 300 days after the man and woman "ceased to cohabit": there is no express mention of a birth that has occurred within 300 days of the termination of the relationship "by death".[151]

The Commission is of the view that the existing situation is unsatisfactory, the burden of the legislative gaps or inattention falling primarily on the artificially conceived child. We see no reason why the child should not be registered as the child of the mother's deceased husband where his sperm was used to inseminate her artificially. Nor, given the general assimilation of the position of married couples and unmarried couples, do we see any reason for distinguishing the position of the child of the latter from the position of the child of a married couple. Accordingly, the Commission recommends that, where a woman gives birth to a child conceived posthumously by means of her deceased husband's or partner's preserved sperm, the woman should be entitled to register the birth showing the deceased as the father of the child and giving the deceased's particulars as those of the child's father.

(iv) Inheritance Rights of Artificially Conceived Children

a. Where Donor Gametes are Used

In a previous section,[152] the Commission recommended that a child conceived artificially with donor gametes should be recognized in law to be the natural child of the woman giving birth and her consenting husband or partner. However, some have suggested that, notwithstanding this assimilation of the position of artificially and naturally conceived children, an exception should be made in the case of the law of succession. It is argued that fidelity to genealogical lines is an important historical principle of succession[153] and that, as a result, genealogical continuity in family relationships is entitled to respect after death.

In practice, the issue manifests itself where, for example, a testator's will contains such language as "to John and the heirs of his body", and where, unknown to the testator, John's wife has had a child through A.I.D. Strictly speaking, the child falls outside the language of the will. In such a case, the testator's intention to benefit the artificially conceived child cannot be assumed from the mere fact of testamentary disposition, evidenced by the will itself. His gift may have presupposed a biological connection with John. Moreover, other beneficiaries have an interest in disputing the claim of an artificially conceived child where the strict language of the will would seem to exclude him or her.

---

[149] *Ibid.*, s. 5(2).

[150] *Ibid.*, s. 8(1)4.

[151] *Ibid.* Termination by death, along with termination by divorce and a judgment of nullity, are referred to in the relevant provision respecting married couples: *ibid.*, s. 8(1)2.

[152] *Supra*, this ch., sec. 3(d)(i).

[153] See Glendon, *The New Family and the New Property* (1981), at 105 *et seq.*

There are, then, several values that are important in the community and in testamentary law, and these values may well conflict where an artificially conceived child is involved and specific or unambiguous language has not been used to accommodate the child in a will. Beneficiaries must be given their rightful portions; and the intent of testators must be a paramount consideration in the interpretation of wills. The problem is that, without specific inclusory or exclusory language, it may be impossible to tell what a testator would have wanted had he or she known of the biological origins of the child in question.

But, aside from this practical or evidentiary problem, and subject to one caveat, the Commission sees no reason why, as a matter of public policy, its previous recommendation respecting the status and parentage of artificially conceived children should be restricted so as to exclude inheritance rights. While there are other legal consequences attaching to our proposal — relating, for example, to support and custody — inheritance is a vital concomitant of status and parentage. As a matter of principle, we do not believe that we should provide an artificially conceived child with an assured legal status *vis-à-vis* his social father and then subsequently deny him the legal benefits that flow from such status.

We said, however, that this conclusion is subject to one caveat. Let us assume, for example, that the grandfather of an artificially conceived child knows of the biological origins of that child and does not wish the latter to inherit through him. The grandfather might simply exclude the child by specifically naming the beneficiaries and leaving the child out. Or the testator may leave property to the heirs of the infertile man's body, thereby excluding the child.

In these cases, where it is clear from the language of the will that the testator does not intend to benefit the artificially conceived child, we are of the view that the testator's intentions should prevail. As a general principle, no one should be forced to benefit another by means of a testamentary disposition.[154] We are buttressed in this view by the analogous provisions of the *Child Welfare Act* and the new *Child and Family Services Act, 1984* dealing with the inheritance rights of adopted children. Section 86(3) of the former and section 152(4) of the latter basically provide that such children should be deemed to be the natural children of the adopting parents for the purpose of inheritance, "unless the contrary is expressed" by the testator. A similar principle is evinced insofar as children born out of wedlock are concerned: for the purpose of construing any instrument, Act, or regulation, such children are to be treated in the same way as children born within wedlock, "unless the contrary intention appears".[155] We are of the opinion that this exception to the general rule is reasonable.

---

[154] We are aware, of course, of the dependants' relief provisions of the *Succession Law Reform Act*, *supra*, note 128, which permit dependants to apply for support where adequate provision has not been made for such persons by the deceased.

Accordingly, consistent with our earlier proposals respecting the status and parentage of children conceived artificially with donor gametes, we recommend that, unless the contrary is expressed by the testator, such children should acquire inheritance rights to the estates of those persons who are legally recognized as their parents, and to the estates of others as if they were the natural children of such parents. It is further recommended that such children should have no inheritance rights through the gamete donors, unless, of course, the donors expressly provide for the children in their wills.

b. Posthumous Artificial Conception, Where No Donor Gametes are Used

It will be recalled that, in respect of the registration of a child posthumously conceived by means of the sperm of a deceased husband or partner, the Commission recommended that the child should be registered naming the deceased man as father.[156] The question arises, then, concerning the inheritance rights of such a child.

We see two issues involved: first, the issue of principle, namely, whether the child should be entitled to inherit through his or her legal father; and secondly, whether the position of the child posthumously conceived with the sperm of the mother's deceased male partner should be assimilated to that of a child posthumously conceived with the sperm of the mother's deceased husband.

Dealing first with the main issue, the Commission clearly favours, in principle, giving the child rights of inheritance as though he or she were the natural child of the man in question, conceived in his lifetime. We believe that this conclusion follows directly from our earlier proposals respecting status and parentage.

However, the implementation of this general conclusion would be impracticable, or unacceptably disruptive, where the estate has already been distributed according to the provisions of the will or the law of intestate succession. If such distribution has occurred, the Commission considers that the dispositions made should not be disturbed. Similarly, distribution should not be postponed simply because sperm is held in cryopreservation. It is recommended, however, that a posthumously conceived child of a husband should be entitled to inheritance rights in respect of any undistributed estate once the child is born or is *en ventre sa mere*, as if the child were conceived while the husband was alive.[157]

---

[155] *Children's Law Reform Act*, *supra*, note 122, s. 2(1).

[156] See *supra*, this ch., sec. 3(d)(iii)2.

[157] We therefore reject the proposals of the Warnock Committee to the effect that a child who was not *in utero* at the date of the death of its father should be disregarded for the

Moreover, such a child should be entitled to inheritance rights where the child is born or is *en ventre sa mere* when the time for the ascertainment of possible beneficiaries arrives. For example, the testator may leave a life estate to X, after which the property would pass to the testator's "children" then alive. If, at the death of X, there exists, or is *en ventre sa mere*, a posthumously conceived child of the testator, that child should be entitled to share.

The second issue to which reference was made concerns the status of a posthumously conceived child of a man who lived in a nonmarital union with the mother. There is an argument that such a child should not be treated in the same way for inheritance purposes as the posthumously conceived child of a woman and her deceased husband. In the latter case, it has been suggested, it may more readily be presumed from the nature of the relationship (marriage) that the man would wish the child to inherit through him, but that no such assumption should be made where the man did not have the same type of formal connection with the mother.

The Commission does not accept these views. We do not believe that one can conclude that a man in a nonmarital union must be presumed to have a different intention than that of a married man with respect to any child conceived posthumously with his sperm. Moreover, it bears mentioning that the *Succession Law Reform Act*[158] does not distinguish between children on the basis of their parents' marital status. Accordingly, we recommend that the position of a child posthumously conceived with the sperm of the mother's deceased partner in a nonmarital union should be the same as that of a child posthumously conceived with the sperm of the mother's deceased husband.

(e) MEDICAL RECORDS

In an earlier section, we recommended that legislation should expressly provide that artificial conception procedures constitute the "practice of medicine" under the *Health Disciplines Act*.[159] As a result of this proposal, such procedures could be undertaken only by licensed physicians[160] or others authorized to act under their supervision or direction.[161] Implementation of this proposal would bring in its train several important legal consequences regarding medical records.

First, the present requirement to keep medical records on patients, expressed in the regulations passed under the *Health Disciplines Act*,[162] would apply to artificial conception procedures. Secondly, the failure to maintain

---

purposes of succession to and inheritance from the latter: see Warnock Report, *supra*, note 2, para. 10.9, at 55, and para. 10.15, at 57.

[158] *Supra*, note 128, s. 1(2).

[159] *Supra*, note 25. See *supra*, this ch., sec. 3(a).

[160] *Health Disciplines Act*, *supra*, note 25, s. 52.

[161] *Ibid.*, s. 50(k). See, generally, *supra*, ch. 3, sec. 2.

[162] R.R.O. 1980, Reg. 448, s. 29(1).

adequate records would be professional misconduct on the part of the physician.[163] Indeed, it might well be professional misconduct where a physician failed to maintain records required for the conscientious and professional care of persons, other than patients, to whom legal, fiduciary, or ethical duties are owed.[164] These other persons could include artificially conceived children, who, while not patients, have frequently been said to be persons to whom physicians owe at least ethical duties. Thirdly, under traditional negligence law, there would likely be a legal duty of appropriate record keeping owed to patients and others, including children, who foreseeably might be prejudicially affected by the failure to keep such records.

In addition to legal obligations imposed on physicians, we have seen that other legislation governs the retention, ownership, confidentiality, and destruction of medical records in public hospitals.[165] Similarly, the Canadian Medical Association *Code of Ethics*,[166] to which the College of Physicians and Surgeons of Ontario subscribes, contains provisions dealing with confidentiality of medical records and patient information. These provisions may be enforced through the professional misconduct provisions of the *Health Disciplines Act* and the regulations passed thereunder.[167]

The legislation, regulations, and professional ethical guidelines respecting the keeping and confidentiality of medical records have been discussed in some detail in chapter 3.[168] As we indicated there, the questions of confidentiality and anonymity are particularly important in the case of medical records respecting artificial conception services.

The Commission believes that, while the governing legislation and ethical guidelines with respect to the maintaining of medical records are not entirely satisfactory for all purposes,[169] they appear to be quite comprehensive and satisfactory insofar as they relate to the recording of artificial conception services. Physicians are under statutory, regulatory, and ethical obligations to keep records and maintain their confidentiality, and we are of the view that, at this general level — dealing with records of medical care — it would be unnecessarily duplicative to enact specific artificial conception legislation mandating what is already obligatory. There is no indication that a particular abuse has occurred in respect of the recording of artificial conception services. To the extent that reform is thought to be necessary in the area of medical records, it should comprehend all health care services and not merely one, relatively small, field of medicine.[170] Accordingly, we recommend that, subject to the recommendations that follow, no specific legislation or rules dealing with medical records relating to the provision of artificial conception services should be enacted or established.

---

[163] *Ibid.*, s. 27.3.

[164] See *ibid.*, s. 27.32, which defines "professional misconduct" to mean, *inter alia*, "conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional".

[165] See *Public Hospitals Act* R.S.O. 1980, c. 410. See, also, *supra*, ch. 3, sec. 6.

[166] Canadian Medical Association, *Code of Ethics* (September, 1982).

[167] See, generally, *supra*, ch. 3, sec. 6.

[168] See *ibid.*

[169] See Ontario, *Report of the Commission of Inquiry into the Confidentiality of Health Information* (1980) (hereinafter referred to as "Krever Report"), discussed *supra*, ch. 3, sec. 6.

Turning now from the keeping of medical records generally to certain specific matters, we are of the opinion that artificial conception does exhibit several unique characteristics that require attention.

First, we shall consider a matter relating to information concerning gamete donors. As we indicated in chapter 3, it is not clear that donors, particularly sperm donors, are "patients" for the purpose of the record keeping provisions of Ontario legislation. In order to ensure that the legislation and other guidelines respecting medical records are as comprehensive as possible, particularly in light of a proposal to be made subsequently concerning a record of linkage between donors and recipients, we recommend that the relevant statutes, regulations, and professional rules be amended to make it clear that gamete donors are patients for the purposes of record keeping. We now turn to a second issue, dealing with the question of linkage.

In chapter 3, we noted that a system of linkage in medical records — permitting doctors to link donors to recipients and, thereby, to their offspring — may be of critical importance where medical or genetic information is required, either in an emergency or otherwise. An artificially conceived child may be born with some disability directly related to the medical or genetic characteristics of the donor. In such a case, treatment of the child may require access to health information concerning the donor and the donor's family medical history. Or vital medical information — for example, affecting future decisions concerning reproduction — may come to light and should be communicated to the donor or to his or her other children. Only a system of linkage can ensure the provision of the requisite medical information to the appropriate persons.

Many of the bodies that have considered the question of medical records in the context of artificial conception have concerned themselves with matters relating to linkage. Generally, there has been a predisposition in favour of maintaining a system of linkage, in some cases to facilitate the provision of necessary medical information to one party or another, in other cases to facilitate access to basic information concerning a donor's ethnic origin and genetic health.

The Commission understands that, as a matter of practice, most doctors do in fact keep records that link donors to recipients, while at the same time preserving their anonymity.[171] We wish to express our endorsement of the present general practice of anonymously linking donors to recipients in medical records. Indeed, we think that the matter ought to be taken one step further. While we do not believe that furtherance of this practice, in an attempt to make it universal, should be promoted by statutory enactment, we do recommend that, pursuant to the power given to the Council of the College of Physicians and Surgeons of Ontario under section 50 of the *Health Disciplines Act*,[172] the Council should make regulations that would establish a system of record keeping permitting doctors to link gamete donors with recipients. However, again in light of our subsequent proposals, we wish to underscore our concern lest the actual identity of the donor be divulged. Accordingly, we recommend that anonymity concerning the identity of all parties involved in artificial conception — the donor, the recipient, her spouse or partner (if any), and the child — should be preserved in the medical records.

---

[170] Most of the reports surveyed by the Commission specifically recommend the keeping of adequate, confidential records respecting artificial conception. However, most of the discussion in the reports deals with certain specific issues, such as disclosure, that we shall consider in the text immediately following.

The preceding recommendation, it should be emphasized, is concerned exclusively with the preservation of the anonymity of the parties among themselves. However, as we have indicated, it may be necessary for a doctor (but not recipients or children) to trace donors after children have been born using their gametes. To repeat, the most important reason for such tracing would be to discover relevant genetic or other information from the donor in order to treat the artificially conceived child or to convey relevant genetic information to the donor or, perhaps, to his or her other biological children.

The Commission recommends that, where a genetic or transmissible defect or disease in a donor or a donor's child becomes known to a doctor, the doctor should be under a duty, imposed by regulations governing the medical profession,[173] to make all reasonable efforts to report all relevant information to any person whose health and welfare the doctor reasonably believes may be affected by it. Sanctions for the failure to abide by such a regulation should lie in potential civil liability in negligence and in the "professional misconduct" regulations under the *Health Disciplines Act*,[174] rather than in a specific new penalty.

A third matter to which special attention should be given concerns whether practitioners engaged in an artificial conception practice should be legally obligated to follow up the results of any procedure, for example by attempting to ascertain whether conception has taken place and, if so, whether any child who is born suffers from the kinds of genetic or other defect or disease to which reference was made earlier. This issue, then, is intimately related to the preceding one respecting the doctor's duty to report defects in artificially conceived children to others.

---

[171] See *supra*, ch. 2, sec. 3(b)(i).

[172] *Supra*, note 25. Section 50(g) provides that, "[s]ubject to the approval of the Lieutenant Governor in Council and with prior review by the Minister [of Health], the Council may make regulations ... (g) governing standards of practice for the profession". As we have seen, regulations have been made, dealing, *inter alia*, with medical records: see R.R.O. 1980, Reg. 448, ss. 29 and 27.3.

[173] See *supra*, note 172.

[174] R.R.O. 1980, Reg. 448, s. 27.

Although a system of follow up is obviously desirable, as a practical matter it is often impossible or impracticable for the artificial conception practitioner to obtain information about any subsequent conception and birth. To ensure secrecy, at least at this stage, the recipient woman who has conceived artificially usually leaves the services of that practitioner for her own doctor, who may be unknown to the artificial conception practitioner. The latter may simply assume that the woman has become pregnant or has given up the attempt, and that, if she has conceived, she will be seeing her own doctor henceforward.

The Commission does not believe that it is feasible to go beyond present practice, which in some, but not all, cases may well involve some follow up after artificial conception procedures have been used.[175] Accordingly, we recommend that there should be no positive duty on artificial conception practitioners to take steps to ascertain whether conception and birth have taken place or to ascertain the medical status of any child. However, should it be thought necessary or desirable to deal more formally with this matter, we recommend that any legal obligation to follow up the outcome of artificial conception treatment should be incorporated in the regulations governing the medical profession under the *Health Disciplines Act*.

A final matter relating to medical records in the context of artificial conception concerns access to such records by recipients, their husbands or partners (if any), donors, and artificially conceived children. A subsidiary, albeit no less critically important, question is, assuming access, whether disclosure should be limited to non-identifying information contained in the records, or whether the identity of the parties should be revealable and, if so, under what circumstances. With respect to the latter question, it bears repeating that earlier we recommended anonymity in the general context of linkage. The issue here is whether an exception should be made for any of the persons involved, particularly the child.

Before we deal specifically with access to medical records, we wish to raise the critical threshold question concerning whether a child should be told of his biological origins.[176] Unfortunately, the answer to this question depends, in part, on interpretations of data that vary significantly and, indeed, on data that has not been gathered to the satisfaction of social scientists, even from the analogous and more accessible field of adoption. The social and psychological ramifications of disclosure are simply not clear; one cannot accurately predict the implications in individual cases.

---

[175] In some cases, donors and their artificially conceived children may be protected where the mother of an impaired child, needing the information contained in the medical records of the artificial conception practitioner, communicates with that practitioner herself, or gives to her new physician the name of the practitioner, so that the donor may be sought.

[176] See, generally, Berger, "Psychological Aspects of Donor Insemination" (1982), 12 Int. J. Psychiatry in Med. 49, and Simanek, "Adoption Records Reform: Impact on Adoptees" (1983), 67 Marq. L. Rev. 110.

With respect to the issue of disclosure, we agree in principle with the view expressed in a Report of the Royal College of Obstetricians and Gynaecologists in the United Kingdom that "the decision to disclose to the child the nature of its parentage should at the present time remain with the 'legal' parents".[177] The decision, we believe, does not lend itself any more to legislative resolution in the artificial conception context than it does in the adoption context, where disclosure of status is not mandated by statute or otherwise, but is left to the legal parents, or, in some cases, others. Each family situation is different, so that a general hypothesis — that, for example, secrecy is deceitful and fundamentally unhealthy — while perhaps reasonable and compelling in the abstract, cannot be translated into a meaningful statutory directive. To counsel common sense, bearing in mind all the circumstances of each case, such as the child's age and temperament, is likely all that can usefully be done concerning this particular matter.

Returning to the separate question of access to medical records, we have seen that the mere existence of medical records does not compel or, indeed, justify disclosure. Confidentiality is the norm. However, recent legislative developments make manifest, at least in some small measure, a movement away from a doctrinaire approach to this issue. Aside from exceptions for essentially medical or related reasons contained in the new *Child and Family Services Act, 1984*,[178] the most obvious example of this movement away from rigid nondisclosure occurs in the adoption context[179] in respect of the "voluntary disclosure register". Without canvassing the matter in detail here, it should be noted that the

---

[177] See RCOG Report, *supra*, note 48, para. 14.4.12, at 18:

> [T]he identity of donors should not be revealed and indeed the donor arrangements should be such that anonymity is inviolable .... [T]he decision to disclose to the child the nature of its parentage should at the present time remain with the 'legal' parents. This should apply equally to children resulting from AID or from IVF and ER. In the event of the parents making such disclosure the child should have access to the same information regarding the genetic background of the donor as was available to its parents without breaching anonymity. If AID or IVF has been employed to avoid transmission of a genetic defect the parents should consider how this information can be conveyed to the child in the event of their premature deaths.

In the British Columbia Royal Commission Report, *supra*, note 42, it was recommended that "[t]he child should not have the fact of his origin by artificial insemination divulged to him" (*ibid.*, at 14, recommendation 7), except if nonidentifying information must be obtained for medical reasons (*ibid.*, at 27, recommendation 16).

[178] *Supra*, note 41, ss. 157(2)(d) and 166(1)(f).

[179] But see *Child and Family Services Act, 1984*, *supra*, note 41, s. 157(1), which provides:

> 157.-(1) Despite the provision of any other Act, no person shall inspect, remove, alter or permit the inspection, removal or alteration of information that relates to an adoption and is kept,
>
> (a) by the Ministry;
>
> (b) by a society or licensee; or
>
> (c) in the register maintained under section 158,

Child Welfare Act[180] has established such a register. Where an adopted child, eighteen years of age or older, and a person who was his or her parent at the time of birth, place their names in this register, a procedure is in place for mutual disclosure of identifying information where, *inter alia*, the adopting parent consents.[181]

The reports that have canvassed the issue of disclosure have generally favoured anonymity respecting the identity of the parties, although not respecting medical or other related information. The Warnock Committee recommended a relatively open system, for it was of the view that, "on reaching the age of eighteen the child should have access to the basic information about the donor's ethnic origin and genetic health and that legislation be enacted to provide the right of access to this".[182]

With respect to the question of access to medical records after a child has, in fact, discovered that he or she was artificially conceived, a minority of the Commission considers that specific legislation is justifiable. These Commissioners would recommend that children born of donated gametes and their legal parents[183] should be entitled to access to all but personally identifying information respecting the donors. A single Commissioner would also grant donors access to nonidentifying information concerning the women and children affected by their donations.

The majority of the Commission, however, does not wish to go this far in respect of access to medical records. They do not believe that legislation could be adequately drafted to take into account the very different needs and emotional makeup of the children in question. In some cases, disclosure of all relevant, nonidentifying information contained in the doctor's record may be appropriate and desirable, while, in other situations, disclosure of some of the information may be more harmful than silence. Accordingly, by a majority, the Commission recommends that the decision concerning access to medical records by the parties involved — the woman, her husband or partner (if any), the child, and the donor — should be left to individual members of the medical profession. However,

---

> or disclose or permit the disclosure of such information that the person obtained from the records of the Ministry, the records of a society or licensee, or the register maintained under section 158.

Section 157(2) contains some exceptions to the rule in s. 157(1). For example, s. 157(2)(a) provides that s.s. (1) does not apply to "the inspection or disclosure of information in accordance with section 158". See text immediately following.

[180] *Supra*, note 41.

[181] *Ibid.*, s. 81(6)(b). See, also, the new *Child and Family Services Act, 1984, supra*, note 41, s. 158.

[182] Warnock Report, *supra*, note 2, para. 4.21, at 24-25. This proposal presupposes, of course, that the child has already been told of, or has otherwise discovered, his biological origins. See, also, Queensland Report, *supra*, note 1, at 56, and RCOG Report, *supra*, note 46, para. 14.4.12, at 18.

[183] See *supra*, this ch., sec. 3(d)(i).

under no circumstances should any doctor or other person disclose information that could in any way identify the parties involved.[184]

(f) ARTIFICIAL CONCEPTION AND LEGAL LIABILITY

(i) Concealment and Misrepresentation of Information by Gamete Donors

When considering the criteria for selection of gamete donors, the Commission emphasized the critical importance to the prospective parents, and particularly to the resulting child, of the selection of suitable gamete donors.[185] In order to ensure, as much as possible, that donors with genetic or other transmissible diseases are not used, the Commission recommended that the question of a donor's genetic and medical status should be governed by professional guidelines to be set by the medical profession. Moreover, since, under our proposals, artificial conception services would constitute the "practice of medicine",[186] the whole panoply of professional medical standards would be brought to bear on the process of gamete donor selection.

Proper professional screening of prospective donors, including adequate genetic and related testing, should minimize risks relating to donation. However, medical science remains dependent, at least in part, on information provided directly by the person tested. The acquisition of family histories and other important information from patients requires intelligent and diligent probing. There is room for human error and mistake. In some cases, likely to be rare, donors may even deliberately conceal information or misrepresent facts or events. To the extent that laboratory and other scientific testing cannot act as a sufficient safeguard against such conduct, it may be thought necessary to provide special legal sanctions against donors.

At present, the *Criminal Code*[187] creates offences for criminal negligence causing bodily harm[188] and for obtaining money by false pretenses.[189] The

---

[184] It bears mentioning that the medical profession's *Code of Ethics*, *supra*, note 166, Responsibilities to the Patient, para. 6, provides that a physician "will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him to do so". Arguably, "information ... regarding a patient" is restricted to identifying information.

Mention should also be made of the regulations under the *Public Hospitals Act*, *supra*, note 165, which substantially limit access to medical records in public hospitals. For example, access by a physician is at the discretion of the hospital board. Indeed, no member of the public, including a patient, has a direct right to remove, inspect, or receive information from a medical record in a public hospital. See R.R.O. 1980, Reg. 865, s. 49.

[185] See *supra*, this ch., sec. 3(c)(i).

[186] See *supra*, this ch., sec. 3(a).

[187] R.S.C. 1970, c. C-34.

[188] *Ibid.*, s. 204.

[189] *Ibid.*, ss. 319-20.

Commission is of the view that, while the existence of these criminal sanctions may well act as a deterrent in some cases, the Province should, and constitutionally can,[190] go further to create a provincial offence dealing expressly with the conduct described earlier. We believe that the matter is of sufficient importance to warrant such a specific provision in the law of Ontario.

The Commission has considered three alternative types of provincial offence, one rendering it an offence knowingly to conceal or misrepresent information in offering or agreeing to donate gametes for artificial conception purposes, another rendering it an offence negligently to conceal or misrepresent information in such circumstances, and, finally, one rendering it an offence simply to provide false or misleading information, whether innocently, negligently, or fraudulently.[191]

We believe that the last mentioned option, creating a provincial offence in the absence of demonstrable fault, is unjustifiably excessive. Such a Draconian measure might even serve to discourage donations by honest persons, fearful of providing incorrect information despite their best intentions.

A regime founded on negligent conduct, while less severe, is also, we believe, unwarranted. We are of the view that the potential for civil liability at the suit of those persons to whom the donor has a legal duty to take reasonable care, and who have been injured by the donor's negligent conduct, is a sufficient response to this type of conduct.

We are left, then, with the more traditional type of offence, requiring the prosecution to prove the donor's wrongful intent to conceal or misrepresent information. To the extent that the existence of such a sanction can act as a deterrent to unacceptable conduct, this regime, in our view, would best serve to protect the interests of the parties. Accordingly, the Commission recommends that it should be made a provincial offence knowingly to conceal or misrepresent information in offering or agreeing to donate gametes for artificial conception purposes. Knowledge by prospective donors that such an offence exists should help to emphasize the significance and seriousness of donation.

(ii) Products Liability and the Supply of Gametes and Embryos

The possibility that the federal government will regulate the supply of sperm, at least for the purpose of licensing sperm banks,[192] gives added point to the question of liability for the direct and indirect supply of gametes, including embryos, that lack the genetic or other attributes claimed for them by their suppliers, that is, gamete donors, gamete banks, and artificial conception practitioners. While the implementation of our proposals respecting donor selection and donor liability under a new provincial offence provision would certainly help to reduce risks to those involved, the use of gametes does carry irreducible minimum risks that may lead to untoward consequences.

---

[190] See *Constitution Act, 1867*, 30-31 Vic., c. 3 (U.K.), s. 92.15.

[191] See *R. v. City of Sault Ste. Marie*, [1978] 2 S.C.R. 1299, 85 D.L.R. (3d) 161, for the distinction between traditional, strict, and absolute liability offences.

[192] See *supra*, ch. 3, sec. 4(b).

Liability for the supply of gametes may be imposed under both contract law and tort law. Leaving aside the application of negligence law and, at this juncture, focusing exclusively on strict liability in the law of torts, it has been said that "no general principle of strict liability for defective products has been announced by any court".[193]

Indeed, in our *Report on Products Liability*, the Commission stated that it was "of the firm view that the most rational basis for dealing with the rights of a person injured by a defective product is to create a direct right of action, not dependent on contract, against the supplier of the defective product".[194] The Commission's draft *Products Liability Act*[195] would provide a right of action to an injured person "[w]here in the course of his business a person supplies a product of a kind that it is his business to supply ..." and where the product in question was defective and caused the injury.[196] A "product" was defined to mean "any tangible goods", and "to supply" was defined to mean "to make available or accessible by sale, gift, bailment or in any other way ...".[197] It is not unreasonable to suggest that the supply of gametes, at least by gamete banks, would fall within these provisions. Consequently, if the proposals in our earlier Report were implemented, principles of strict liability would apply to the supply of gametes and embryos.

However, the area in which these principles make their greatest mark is that of contract law. At present, there is uncertainty in the legal literature and case law concerning whether the supply of biological products attracts liability as a sale of goods or as the rendering of a service, and whether this distinction is applicable in provincial law to lead to different results. In Canada, if the supply of gametes is characterized as a sale of goods, the implied warranties of merchantable quality and fitness for a specified purpose would apply;[198] indeed, analogous warranties may apply if the supply of gametes is characterized as the offering of a service.[199] Consequently, any failure of result would leave both donor and practitioner liable even in the absence of negligence.[200]

---

[193] Ontario Law Reform Commission, *Report on Products Liability* (1979), at 21. However, strict liability principles have been invoked in a small number of tort cases: see *ibid.*, at 20-21.

[194] *Ibid.*, at 64.

[195] *Ibid.*, Appendix 1, at 135.

[196] Draft Bill, s. 3(1), in part.

[197] *Ibid.*, s. 1(1)(c) and (d), respectively.

[198] See *Sale of Goods Act*, R.S.O. 1980, c. 462, s. 15.

[199] Waddams, "Implied Warranties and Products Liability", in Law Society of Upper Canada, *New Developments in the Law of Torts* (1973) 159, at 162-64.

[200] See, generally, *ibid.*, esp. at 163 *et seq.*

In the United States, several courts have held that implied warranties are confined to sale of goods transactions.[201] Blood donation has regularly been held to be a service, rather than a sale of goods, transaction. Accordingly, suppliers of blood, whether individual donors, philanthropic agencies, or commercial blood banks, are not held to the implied warranties of merchantable quality and fitness for purpose, although they do bear ordinary civil liability where a plaintiff proves negligence, for instance, in the case of inadequate screening of donors.[202] This position would appear to result from a recognition of the critical need for blood donation services, and of the likelihood that the application of strict liability principles would discourage individuals and agencies from undertaking the supply of blood.

The question is, then, whether the need to ensure a supply of gametes for artificial reproduction is comparable to the need to ensure a supply of blood for transfusion. If it is considered that the needs of those whose reproduction is dependent upon donated gametes are sufficiently meritorious or pressing, a regime under which strict liability principles, and particularly the implied warranties of quality and fitness for purpose, would apply would have to be rejected as having an inhibiting, counter-productive effect, by tending to lessen the availability of such services. The fact that the provincial health insurance plan covers A.I.D. and diagnostic services leading to I.V.F. may indicate that the practice of gamete donation does, in fact, respond to a call for services considered worthy of protection.

The Law Reform Commission of Saskatchewan has stated that, "while categorization of the transaction in this way [as a sale of goods, bringing in train the implied warranties] should cause few problems, it is generally undesirable to have law designed for commercial transactions involving chattels applied to the relationship between a donor and a collector of semen",[203] or, presumably, between a doctor and recipient. Accordingly, it was proposed that the transaction in question should not be treated as a sale of goods and that no implied warranties should apply.[204]

The Commission agrees in principle with this conclusion. Indeed, we would go further and reject the application of strict liability generally, whether arising in the context of contract or tort. We believe that compensation and deterrence are satisfactorily ensured by the ordinary law of negligence. Finally, we are of the view that imposing strict liability on the donation or supply of gametes, even by commercial gamete banks, would substantially reduce the number of gametes available to treat infertile or genetically impaired persons. Our conclusion in this matter does not ignore the fact that gametes may be defective. However, our earlier proposals respecting the screening of gamete donors, as well as normal medical practice, will serve to eliminate gametes that should not be used in an artificial conception programme.[205] Moreover, standards of screening sperm donors will be influenced by the criteria that may be proposed by the federal government through its announced scheme to license sperm banks. Accordingly, the Commission recommends the enactment of legislation that would provide that principles of strict liability, and particularly the implied warranties of merchantable quality and fitness for purpose, should not be applied to the direct or indirect donation or supply of gametes or embryos;[206] rather, recovery in such a transaction should be dependent upon general principles of the law of negligence.

---

[201] See *ibid.*, at 163, *n.* 17.

[202] See, for example, *Perlmutter v. Beth David Hospital*, 123 N.E. 2d 792 (N.Y. Ct. App. 1954).

[203] Law Reform Commission of Saskatchewan Report, *supra*, note 37, at 3-14.

[204] *Ibid.*, at 3-16, recommendation (9).

(iii) Wrongful Conception, Wrongful Birth, Wrongful Life, and Dissatisfied Life Claims

When discussing, in previous sections, the potential liability of practitioners and donors for conduct in the context of artificial conception, it was stated that the ordinary principles of tort law, including the law of negligence, would and should continue to apply to this branch of medical practice. We need not review here the applicability of that law in the context of artificial conception in those cases where the courts can utilize well-known concepts in a traditional way. For example, the law respecting liability for prenatal injuries ordinarily follows orthodox tort principles and, therefore, warrants no special treatment.[207]

There is, however, a set of claims that is both contentious and widely surveyed in modern United States medicolegal jurisprudence and literature. These claims are represented by a substantial and growing number of difficult cases, in which vigorous dissents are commonplace, and have been addressed by a few state enactments generally hostile to the claimants.[208] The different claims may be characterized as follows:

---

[205] See *supra*, this ch., secs. 3(c)(i), (vii), and (viii).

[206] Legislation implementing this proposal would be an exception to s. 3(1) of the Commission's draft *Products Liability Act*, reproduced *supra*, this sec., at least insofar as commercial gamete banks, in the "business" of supplying gametes, are concerned.

With respect the application of the implied warranties to the supply of defective medical products by physicians, see Waddams, *supra*, note 199, at 164, where the author stated that "there may be considerations of social policy that would justify the exemption of medical practitioners from the scope of strict liability ...". For the reasons advanced in this Report, we agree, at least insofar as the supply of gametes and embryos is concerned.

[207] Aside from a small number of cases and one statutory provision, there have been very few developments in Canadian jurisprudence respecting prenatal injuries. See, for example, *Duval v. Seguin*, [1972] 2 O.R. 686 (H.C.J.), aff'd (1974), 1 O.R. (2d) 482 (C.A.), and *Steeves v. Fitzsimmons* (1975), 11 O.R. (2d) 387 (H.C.J.). See, also, s. 67 of the Ontario *Family Law Reform Act*, *supra*, note 127, which provides that "[n]o person shall be disentitled from recovering damages in respect of injuries incurred for the reason only that the injuries were incurred before his birth".

While claims in respect of postconception injuries appear to be fully accepted, and are commonplace in the United States, a debate still rages in respect of preconception injuries. See, for example, *Albala v. City of New York*, 445 N.Y.S. 2d 108, 429 N.E. 2d 786 (1981), where the Court rejected a claim for such injuries.

1. *wrongful conception*, brought by a woman and, perhaps, her spouse or male partner, where she conceives and a child is born after a negligently performed sterilization or abortion, or after having been given negligent contraceptive advice, whether or not the child is defective;
2. *wrongful birth*, brought by a woman and, perhaps, her spouse or male partner, where she conceives and a child is born after the negligent failure of another person, before or after conception, to advise, counsel, or test the child's parents concerning genetic risks or other related matters, so that the parents are precluded from making an informed decision whether to avoid the conception or to avoid the child's birth, as the case may be;
3. *wrongful life*, brought by the child or the child's estate, on the ground that the child should not have been conceived or born, but was so, due to negligence of the type described in paragraph 2, as a result of which the child is forced to bear pain and suffering because of a predictable defect;[209] and
4. *dissatisfied life*, brought by a child, where, through the negligence of another person, a child is born medically "normal", but into conditions of social, psychological, economic, or other nonmedical "disadvantage", such as illegitimacy.

These claims have received increased attention as a result of greater recourse to preconception genetic diagnosis and counselling, and improved means of undertaking prenatal diagnosis by means of, for example, amniocentesis, fetoscopy, and fetal imaging by ultrasound. Claims may also relate, however, to negligent screening of gamete donors for artificial reproduction, negligent handling of gametes and embryos, and the negligent cryopreservation, thawing, or transfer of a gamete or embryo.

While, therefore, claims may clearly arise in the context of artificial reproduction, the relatively small extent of artificial conception services in the practice of medicine as a whole makes it easy to understand why the above claims do not, and will not, represent a very substantial proportion of the wrongful birth and other related claims advanced. The major resort to these claims in litigation in the United States has come, and will likely continue to come, from allegations of negligent sterilization, negligent contraceptive advice, and negligent genetic and prenatal diagnosis and counselling.

---

[208] See, for example, legislation in South Dakota: S.D.C.L., c. 21-55 (1982 Supp.), enacted by S.L. 1981, c. 172, §§1-4.

[209] Accordingly, the claim is not that, without the negligence in question, the child would have been born without the defect, which would constitute an orthodox prenatal injury claim for negligence. Rather the claim is that, in the absence of negligence, the particular child would not have been born at all.

After initial derision and rejection of claims by parents for wrongful conception and wrongful birth in United States jurisdictions, many courts have gradually come to accept these claims as falling within more or less orthodox negligence principles. More recent legal literature addresses not so much the claims themselves, but the heads of damages that should properly be allowed.[210] On the other hand, wrongful life claims by children or their estates, which are by far the most controversial of the claims, have been admitted only in some rather isolated cases;[211] most jurisdictions continue to reject them. And no court has admitted or awarded damages upon a dissatisfied life claim.[212]

A number of American jurisdictions have enacted or have received proposals for legislation designed to disallow wrongful birth and wrongful life claims as a matter of public policy, in part because of their relationship to abortion.[213] A physician facing the prospect of such claims, it is argued, may have an incentive to advise and perform an abortion in order to escape liability. Those opposed to abortion consider that a judicial allowance of these claims would render abortion a medically favoured option, and therefore they are sympathetic to a legislative proscription of such claims. Others accept that individuals are legally free to control their reproduction through recourse to contraception and should not be barred from seeking remedies for a denial of that legal freedom resulting from medical negligence; that is, they believe that medical negligence should not be protected simply because it results in childbirth. However, many would still prohibit wrongful life and wrongful birth claims on the basis that their acceptance would involve an endorsement of what they believe to be the morally indefensible notion that some births are wrongful.

The view that the birth of a child is never a wrong, but (in the words of some judges) is always a "blessing", no matter how great the child's disability or physical or emotional suffering, and that it should therefore not entitle a parent to succeed in a wrongful birth claim or the child to succeed in a wrongful life or dissatisfied life claim, has a bearing upon this Project and its Terms of Reference. The latter direct that special attention be paid to the best interests of the child. This raises the issue whether it can be said in a particular case that it is in a child's best interests not to be conceived, or not to be born into an unsatisfactory social setting.

---

[210] See, for example, Nicholson, "Damages: Recovery of Damages in Actions for Wrongful Birth, Wrongful Life and Wrongful Conception" (1984), 23 Washburn L.J. 309.

[211] See, in particular, *Curlender v. Bio-Science Laboratories*, 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (Ct. App. 1980); *Turpin v. Sortini*, 182 Cal. Rptr. 337, 643 P.2d 954 (Sup. Ct. 1982), vacating 119 Cal. App. 3d 690, 174 Cal. Rptr. 128 (Ct. App. 1981); and *Harbeson v. Parke-Davis, Inc.*, 656 P.2d 483 (Wash. Sup. Ct. 1983). See, also, Kennedy, "The Trend Toward Judicial Recognition of Wrongful Life: A Dissenting View" (1983), 31 U.C.L.A. L. Rev. 473.

[212] See *Zepeda v. Zepeda*, 190 N.E. 2d 849 (Ill. Ct. App. 1963), *cert.* denied 379 U.S. 945 (1964), dealing with the claim of an illegitimate child.

[213] See Donovan, "Wrongful Birth and Wrongful Conception: The Legal and Moral Issues" (1984), 16 Fam. Planning Perspectives 64, and the South Dakota legislation *supra*, note 208.

The contention that it can be in a child's best interests not to be born underlies the wrongful life and dissatisfied life claims. But all jurisdictions reject the latter and most jurisdictions reject wrongful life claims on the public policy ground that, in principle, life is always to be preferred to the absence or denial of life. It bears mentioning, however, that in another context courts have recognized that severely impaired newborn or older children may be denied "extraordinary" treatment, thereby allowing them to die, because that is, in fact, in their best interests.[214]

This brief discussion is designed simply to illustrate the profound and complex issues involved in the determination of liability for negligence resulting in human conception and birth, particularly where the claim involves the notion that, but for the defendant's negligence, the child in question would not have been born. Difficulties are amplified when considering the heads of damages that may be allowed for successful claims, including whether a negligent professional should be required to pay for the upbringing, to majority, of a healthy child living as a normal member of its parents' family, or for the lifelong special nursing needs of a severely handicapped child. Further issues of public policy concern whether actions may be brought by handicapped children not only against negligent physicians who were responsible for their parents' care and counselling, but also against the parents themselves for their negligent or wilful decisions to have or to risk having children with handicaps.[215]

As we indicated earlier, wrongful life and related claims that arise in the context of artificial conception constitute a relatively small proportion of all such claims. These claims exist, and are troubling, within a much broader context encompassing not just medicine, but other health sciences. Accordingly, we believe that the challenges presented by wrongful life and related claims cannot and should not be resolved within the four corners of a report on human artificial reproduction. We therefore recommend that these claims should be the subject of a separate study, so that they may be considered carefully in the context of tort law generally. In this way, proposals for an integrated jurisprudence in the area may be adequately developed.

---

[214] See *Re Superintendent of Family and Child Service and Dawson* (1983), 42 B.C.L.R. 173, 145 D.L.R. (3d) 610 (S.C.), discussed in Dickens, "Withholding Pediatric Medical Care" (1984), 62 Can. Bar Rev. 196, and Sneideman, "The Stephen Dawson Case: Whose Decision is it Anyway?" (1984), 14 Man. L.J. 165.

[215] In Ontario, the law does not now prohibit actions by children against their parents: see *Family Law Reform Act*, *supra*, note 127, s. 66.

4. PROPOSALS RELATING TO THE FERTILIZED OVUM OUTSIDE THE BODY

(a) INTRODUCTION

In chapter 2 of this Report, the Commission described the I.V.F. procedure.[216] We noted that, since laparoscopy — the removal of a mature ovum from the ovary — is a surgical procedure that involves a certain risk, many I.V.F. clinics stimulate menstrual cycles in order to produce superovulation in the woman, so that multiple eggs may be extracted at one time. Another reason for this practice relates to the likely success of fertilization and implantation: there is a greater likelihood of successful fertilization where several ova are exposed to sperm *in vitro*, and the probability of successful pregnancy is increased by transferring more than one fertilized ovum to the recipient's uterus.

To the extent that I.V.F. clinics fertilize more than one ovum at a time and that more ova will be fertilized than will ultimately be transferred to the recipient, vital questions arise concerning the ethical acceptability of this practice and the status and control of a fertilized ovum outside the body. With respect at least to the first question, concerning the ethical acceptability of implanting multiple ova, the absence in Ontario of any formal I.V.F. guidelines concerning this particular matter has forced physicians and clinics to develop their own rules. With respect to the second question, it has been said that the issue of status and control is "[t]he most ethically and politically controversial aspect of I.V.F.".[217]

While the issue of the status of a fertilized ovum outside the body arises mainly in the context of I.V.F., where "surplus" fertilized ova may be produced, it will also be relevant in the context of *in vivo* fertilization and lavage.[218] It should be noted that, given the fact that the failure of lavage may result in the pregnancy of the donor, superovulation is not used in this process, for it would significantly increase the risk of pregnancy.

Although the obvious purpose of donation by *in vivo* fertilization and lavage is to transfer the fertilized ovum very quickly to the uterus of another woman, for various reasons the transfer may never take place. In such a case, the fertilized ovum will not be used by its intended recipient, and its status will become a matter of concern, particularly to the person or facility in possession of it.

In the sections that follow, the Commission will consider the issues described above and other related matters. We turn first to deal with the propriety of the simultaneous transfer of multiple ova to one recipient.

---

[216] *Supra*, ch. 2, sec. 3(b)(ii).

[217] Annas and Elias, "*In Vitro* Fertilization and Embryo Transfer: Medicolegal Aspects of a New Technique to Create a Family" (1983), 17 Family L.Q. 199, at 208.

[218] The process is described *supra*, ch. 2, sec. 3(b)(ii).

(b) THE SIMULTANEOUS TRANSFER OF MULTIPLE OVA

The question whether the practice of transferring multiple fertilized ova to a woman is ethically acceptable involves two considerations. First, there is risk to the recipient that a multiple pregnancy will occur. However, so long as the woman has been fully informed of, and accepts, this risk, we see no reason why it should act as a bar to the procedure.

The second consideration concerns the source of the ova to be transferred. In the case where the recipient can produce her own ova, the Commission is of the view that superovulation and the transfer of multiple fertilized ova ought to be an option open to the recipient and her physician. As a matter of principle, we see no essential difference between this procedure and I.V.F. involving a single ovum from the recipient.

More controversial is the question of multiple transfer where donor ova are involved. Since objection has been taken to the confusion of genetic background of artificially conceived children,[219] it may be argued that only a single donor — who would have to undergo superovulation — should be found. Others, however, have rejected this argument; for them, single or multiple ova could be donated by different donors for transfer together to the recipient.

Given the professional duty of doctors to keep appropriate records, and modern means of genetic identification of parentage, it may be doubted whether prohibitory legislation is required to minimize the risk of uncertainty of genetic origin. No objection has been taken in the reports canvassed by the Commission to the practice of sperm from different donors being used at different inseminations within an individual woman's menstrual cycle. We believe that this principle appears no less acceptable regarding ova.

Accordingly, the Commission recommends that there should be no prohibition of the practice of transferring multiple fertilized ova to a woman, regardless of whether the ova are her own or are donated, and, where the ova are donated, regardless of whether a single donor or different donors are used. The use of such a procedure appears to fall within the legitimate discretion of the medical profession, bearing in mind the nature and extent of a physician's general accountability in respect of his practice.

(c) CONTROL OF A FERTILIZED OVUM OUTSIDE THE BODY

(i) General

We now turn to deal with the critical issue concerning the locus of legal control of a fertilized ovum outside the body,[220] that is, who has the lawful right to determine the use to which the ovum may be put.

---

[219] See Victoria Report on Donor Gametes, *supra*, note 1, para. 6.26, at 46, and para. 6.35, at 48.

[220] We wish to emphasize that the issues raised in this section pertain exclusively to the control of a fertilized ovum, not a gamete. Insofar as the latter is concerned, reference

In chapter 3, when dealing with research and experimentation on human genetic material, the Commission discussed the uncertain state of the law respecting the status and control of human body parts, including embryos.[221] We indicated first that the law does not seem to give the same status to a fertilized ovum as it does to a living child or, perhaps, even a fully differentiated fetus. We also stated that, whether or not body parts, including a fertilized ovum, may be the subject of "ownership",[222] the concept of legal control of the fertilized ovum is a useful one for our purposes. The question therefore arises: how does one determine who has legal control?

We have already stated that the law is not free from serious doubt in this area. Indeed, existing legal doctrine applied to the question of control, the legal and practical consequences of actual possession of the fertilized ovum, and formal preconditions for treatment or donation, involving, on the one hand, physicians, clinics or gamete banks, and, on the other, patients and donors, all bear on this matter.

The Commission's consideration of the locus of legal control will focus on two main candidates, that is, the gamete producers and the person in actual possession of the genetic material. As a practical matter, the two will seldom be the same, since donated gametes and embryos are held by artificial conception physicians, clinics, gamete banks, or research facilities. Consequently, to the extent that the law does not impose a clear solution, there may well be a substantial degree of disagreement between these parties concerning who has control.

We turn first to consider the claim of the gamete producer to legal control. In this connection, it has been suggested that "[t]he person producing the substance has the first right to it, subject to statute".[223]

The notion that the producer of the genetic material has a right, superior to others, to control its destiny, hardly seems radical, particularly in view of the nature of the material in question. Yet, the principle that legal control resides in the gamete producer may be difficult to apply in the case of a fertilized ovum, where sperm and ovum have been inextricably mixed to create new genetic material. For example, what if those with the power of control, that is, the two

---

should be made to an earlier recommendation of the Commission, namely, that after donation donors should be entitled to require that their donations be wasted or returned to them and not used for artificial conception or any other purpose: see *supra*, this ch., sec. 3(c)(iv). Consequently, the donor would have some measure of control over his or her gamete after donation. However, since he or she obviously could not sever the gamete after it has been used in a fertilization process, the preceding right to withdraw the donation would no longer be operative.

[221] See *supra*, ch. 3, sec. 7.

[222] See Matthews, "Whose Body? People as Property", in Lloyd *et al.* (eds.), *Current Legal Problems 1983* (1983) 193, at 224, and Victoria Report on Embryos, *supra*, note 110, para. 2.8, at 27-28.

[223] Matthews, *supra*, note 222, at 224.

gamete producers, disagree with respect to transfer, donation, wastage, or experimentation? Clearly, a sperm donor cannot prevail in insisting upon a transfer of a fertilized ovum to his wife if the latter refuses. Such difficulties may be aggravated if a couple, who are the gamete producers, separate. On the other hand, few problems may arise upon the actual or presumed death of one spouse, since the survivor presumably will gain sole legal and actual control. Not all the permutations of granting and denying consent to different uses or dispositions of a fertilized ovum need to be reviewed, however, in order to make the point that, in the ordinary case, unless both gamete producers agree upon an alternative, wastage will be the ovum's fate, postponable, perhaps, by cryopreservation.[224]

In some instances, the gamete producers may agree to transfer voluntarily their interests in the fertilized ovum to which they have both contributed. In other cases, the general law relating to the abandonment of property may be applicable to give legal control to only one of the producers or to some third party, such as a gamete bank. For example, a couple who have contributed gametes to a fertilized ovum *in vitro*, but who no longer need it to achieve a pregnancy, may leave it in the custody of the physician, without intending to have anything more to do with the ovum. And, in another context, it should be noted that the very purpose of *in vivo* fertilization and lavage is to donate the fertilized ovum to another person; consequently, no thought is ordinarily given to the retention of some control over the donation.

Related to the issue of voluntary transfer or abandonment is the attitude of artificial conception practitioners, clinics, and gamete storage facilities. These persons and institutions need not necessarily be passive agents, leaving the issue of control of donated material to be determined by the general law or, as a practical matter, by the donors themselves. In order to operate free of any possible legal uncertainty, they may impose on gamete donors and potential parents certain conditions respecting the future use or disposition of their gametes. For example, gamete producers may be required to agree that, upon donation, legal control respecting the use and disposition of the donated material should pass exclusively to the practitioner, clinic, or gamete bank. Under these circumstances, where there is a refusal to accept such conditions, the latter will presumably decline to accept the intended donation.

We have seen, therefore, that, even assuming that the gamete producer has legal control over the use and disposition of his gamete, he may transfer or lose this right to another party. However, it may be suggested that legal control of a gamete or fertilized ovum cannot, in fact, be found in the producer where he no longer has actual possession of the genetic material. It may be argued that, whatever the intentions of the producer, legal control automatically passes where possession changes hands, so that legal control always and necessarily resides in the person in possession.

---

[224] In a sense, this result reflects the natural order. In nature, the vast majority of human gametes are wasted: some fail to result in conception; many fertilized ova fail to implant successfully (see Hurtig *et al.*, "Thirty-four fertilized ova ... recovered from 210 women of known fertility" (1952), 23 Pediatrics 202); and 62% of concepti are lost prior to 12 weeks of gestation (see Edmonds *et al.*, "Early Embryonic Mortality in Women" (1982), 38 Fertility and Sterility 447).

On the basis of this argument, the presence or absence of a voluntary transfer, and, indeed, the general law of abandonment, would be irrelevant. A contract ceding legal control of a gamete to a hospital would be functionless, since the mere giving up of possession would lead to the same legal result. An examination of the state of mind of the producer-donor, concerning whether he actually abandoned his interest in the genetic material upon donation, would be equally unnecessary, since, by hypothesis, the loss of possession itself would be determinative of the legal rights of the parties.

The question whether the source of the genetic material or the simple fact of possession is the critical factor in assessing the locus of legal control of a fertilized ovum cannot be resolved here. What is clear to the Commission, however, is the need for the law to be more certain in this area. Existing legal concepts of ownership, property, and control are elusive; decisions made on the basis of *de facto* control alone may not be valid in law; and not all practitioners, clinics, or storage facilities may have the foresight or sophistication to draft comprehensive rules governing their services. The nature and importance of the subject matter in question — the control of fertilized ova outside a woman's body — is such as to necessitate a clarification of the operative rules.

In formulating rules to govern the status and control of a fertilized ovum, several of the reports from outside Ontario have emphasized the need to respect the wishes of the gamete donors.[225] In some cases, reference has been made to the control of the recipient couple.[226] Where the donors do not agree on the use to which the embryo in question should be put, the Queensland Report recommended that the matter should be determined by means of the procedure applicable in custody proceedings.[227] Where this is not possible — for example, where the biological parents die, leaving no instructions — it was proposed that the procedure to be used should be the one applicable in the case of adoption.[228]

The Commission does not believe that the many interests at stake can be adequately accommodated by a single proposal respecting the control of a fertilized ovum. Rather, we are of the view that the complexity of the topic necessarily requires proposals that are more sensitive to the differing circumstances in which the issue of control may arise. We have in mind three situations. In one, the fertilized ovum has been produced from the gametes of the husband and wife or the male and female cohabiting partners; in another, the fertilized ovum has been produced entirely from the gametes of donors; in yet another, the fertilized ovum has been produced in part from the gamete of one of the married or unmarried couple, and in part from a donor gamete. We are of the opinion that the issue of control of a fertilized ovum that, by hypothesis, is not going to be transferred to the woman must be resolved differently for these different situations. We shall now discuss each in turn.

---

[225] See, for example, B.M.A. Working Group Report, *supra*, note 39, para. (10), at 1594, and Queensland Report, *supra*, note 2, at 91.

[226] See B.M.A. Working Group Report, *supra*, note 39, para. (11), at 1594, and The American Fertility Society, "Ethical statement on in vitro fertilization" (1984), 41 Fertility and Sterility 12, para. II, at 12.

[227] Queensland Report, *supra*, note 2, at 91-92.

[228] *Ibid.*, at 92.

(ii) Where No Donated Gametes are Used

Where the couple participating in an I.V.F. programme are contributing their own gametes, and where there is a fertilized ovum that has not been used for the purpose of conception, the Commission sees no practical or ethical reason why the couple should not have joint legal control of that ovum. The main alternative — in effect, deeming control to pass, for example, to the physician or clinic in possession of the ovum — is both unnecessary and undesirable.[229] The couple intended to use the fertilized ovum for the purpose of conception, but no longer need or want to use the ovum for that particular purpose. To this point, the parties have not had any intention other than the use of their own gametes for themselves. Respect for the right of gamete producers to control the destiny of their genetic material seems appropriate in such a case. Should they wish to donate the fertilized ovum to another woman or couple, or have it cryopreserved, or even have it wasted immediately, their wish should be paramount. Their emotional interest in the material is strong enough to warrant their continued right to deal with the ovum.

Accordingly, the Commission recommends that a fertilized ovum outside the body, produced with the gametes of the intended recipient and her husband or partner, should be under the joint legal control of the man and woman. Consequently, for example, the husband or male partner would be entitled to revoke his express or presumed consent to the transfer of the fertilized ovum to his wife or female partner.

Given that, under our recommendation, the fertilized ovum would be under the joint legal control of the couple, a question arises concerning the locus of control where one or both of the parties die, or where they cannot agree on the use to which the fertilized ovum should be put.

In considering the case where the couple had stored an embryo for their own future use, the Warnock Committee offered several proposals for reform. For example, it recommended "that when one of a couple dies the right to use or dispose [of] any embryo stored by that couple should pass to the survivor".[230] Where "both die that right should pass to the storage authority".[231] Furthermore, it was proposed "that where there is no agreement between the couple the right to determine the use or disposal of an embryo should pass to the storage authority ...".[232]

---

[229] See Victoria Report on Embryos, *supra*, note 110, para. 2.16, at 31-32.

[230] Warnock Report, *supra*, note 2, para. 10.12, at 56.

[231] *Ibid.*

[232] *Ibid.*, para. 10.13, at 56-57. The Committee also recommended that there should be "a

The Commission concurs in principle with the proposals of the Warnock Committee. Basically, these proposals recognize the general right of joint legal control in the couple, while at the same time providing for contingencies when agreement is not, or cannot be, forthcoming. Accordingly, the Commission makes the following further recommendation respecting control of a fertilized ovum, bearing in mind our earlier general proposal that the ovum is to be under the joint legal control of the woman and her spouse or male partner. First, when one of the couple dies, legal control of the fertilized ovum should pass to the survivor. Secondly, if both should die, control should pass to the physician, clinic, gamete bank, or other authority that has actual possession of the ovum. Thirdly, where the couple cannot agree concerning the use or disposition of the fertilized ovum, legal control should pass to the physician, clinic, gamete bank, or other authority.

The above recommendations attempt to deal with the control of a fertilized ovum produced with the gametes of the couple who originally intended to use the genetic material. We now turn to consider the issue of control of the fertilized ovum where one or both gametes have been donated.

(iii) Where Donated Sperm or Ova, or Both, are Used

The proposal that a woman and her husband or male partner should have joint legal control over the use and disposition of an ovum fertilized with their own gametes was based essentially on the notion that, *prima facie*, the person whose gamete is used should have a superior right to determine its destiny. On the other hand, we do not believe that such a right is immutable. While a gamete donor should be entitled to restrict or alter the use to which the gamete is put,[233] or withdraw his consent to the use of his or her gamete, at any time prior to the fertilization stage,[234] it is arguable that, in the absence of such action, legal control by a gamete donor should not survive a material change in the status of the gamete, namely, its combination with another gamete in a fertilization process.

At first blush, it may seem anomalous to permit a married or unmarried couple to control a fertilized ovum produced from their own gametes, but to deny such a right to a gamete donor, even where he or she has not restricted the use of the donation. Certainly the biological or genetic connection to the gamete in question is no less real in the one case than in the other.

However, while the biological or genetic nexus is the same in both cases, the two situations differ substantially. Even assuming that a gamete donor has not been obligated to sign an unrestricted donation agreement by the clinic or storage facility involved — and the requirement to donate on this basis may well become

---

maximum of ten years for storage of embryos after which time the right to use or disposal should pass to the storage authority": *ibid.*, para. 10.10, at 56. We shall return to the question of limitation periods *infra*, this ch., sec. 4(f).

[233] See our recommendation *supra*, this ch., sec. 3(c)(iii).

[234] See our recommendation *supra*, this ch., sec. 3(c)(iv).

the norm — the very fact of an anonymous donation, without restriction, bespeaks a willingness to give up control of the gamete. Donations of the kind considered here would not be made to specific individuals; rather, donations would be made to the physician, clinic, or gamete bank for general purposes, ordinarily, but not necessarily, the treatment of infertile persons. Accordingly, the fact that one person does not need the fertilized ovum in question would be of no particular concern to a donor; its use by another person would equally fulfil the purpose of the donation.

We have considered the notion of continued donor control solely from the perspective of the presumed intention of most donors and the nature and purpose of the anonymous, unrestricted donation itself. We have left aside the practical problems that might arise if the advice of hitherto anonymous donors had to be sought out in every case where a fertilized ovum is not transferred to the intended recipient and some other use, or even wastage, is contemplated. Even where they can be traced, one might expect such donors to be rather startled by the thought that their advice is necessary merely because the original recipient no longer needs or wishes to use the genetic material. If the donor had wished to limit the use to which his donation would be put, presumably he would have so indicated to the donee, or, if such a limitation was unacceptable to the donee, he would simply have not made a donation.

Accordingly, for both practical and philosophical reasons, the Commission has come to the conclusion, and therefore recommends, that a gamete donor who has not imposed a restriction on the use of his or her donated gamete prior to fertilization should have no right in law to control the use or disposition of a fertilized ovum to which he or she has contributed genetic material.

Having set forth this recommendation, we must now consider the locus of control in the two cases envisaged in our discussion: (1) where both sperm and ovum have been donated; and (2) where only the sperm or the ovum has been donated.

Given our view that donors who have not restricted the use of their donations ought not to be accorded any right of control once fertilization has taken place, there seem to be three main options where both the sperm and the ovum have been donated on this basis. Control may reside in (1) the physician, clinic, gamete bank, or other storage facility having possession of the fertilized ovum, or (2) the person or couple for whom the ovum was intended, but who no longer wish or need to use it, or (3) both the institution and the couple. Where an intended recipient has no use for the fertilized ovum that was to be transferred to her, the Commission is of the view that her connection with the ovum, both biologically and emotionally, is not such as to warrant giving her any measure of control over its future use or disposition. Having regard to the fact that the fertilized ovum will not be transferred, the intended recipient is now in the position of a stranger to that ovum.

The Commission is also of the view that, whatever the wishes of the couple in the circumstances just described, as a matter of policy they should not be entitled to exercise legal control over the fertilized ovum. That leaves only the person or institution in *de facto* control. It alone has a sufficient interest in the material. Accordingly, we recommend that, where a fertilized ovum has been produced from sperm and ovum donated without restrictions on their use, legal control over the fertilized ovum should reside in the physician, clinic, gamete bank, or other storage facility having actual possession of the ovum.[235]

We now turn to consider the case where the unused fertilized ovum has been produced by a gamete donated generally and a gamete from one of the couple for whom the ovum was intended.

We have already recommended that a gamete donor who has not imposed a restriction on his donation ought not to have any right to control the use or disposition of a fertilized ovum. But, whereas in the case of a wholly donated embryo, there may well be no intended recipient at the time of fertilization, or, if so, she and her husband or partner will have no biological, and probably no emotional, attachment to the unused fertilized ovum, in the present case one of the couple does, in fact, have a significant connection to the genetic material. We believe that the position of the spouse or partner that has such a connection cannot be equated to that of the donor who makes an unrestricted gamete donation. Nor, indeed, do we believe that the position of the former is the same as that of the other spouse or partner, who has not contributed his or her gamete to the embryo. The absence of such a contribution means that he or she would not likely have a particularly strong emotional commitment, if indeed any commitment, to the future destiny of the embryo, although, since his or her spouse or partner has made a contribution, the emotional commitment might presumably be greater than if the embryo were wholly donated.

On balance, the Commission has come to the conclusion that the interest of the non-contributing spouse or partner in an unused fertilized ovum is not sufficiently strong to permit him or her to exercise control over its future. The non-contributor is a stranger to the fertilized ovum, and the very fact that the ovum will not be used for the purpose of conceiving a child for the couple significantly alters the non-contributor's stake in the material from what it would have been had the fertilized ovum been used for its original purpose.

The same cannot be said, of course, for the spouse or partner who has contributed genetic material to the fertilized ovum. Such a person is in the same position as the man and woman who have intended that their own gametes be used for the purpose of conceiving their own child. In the latter case, we stated the view that the couple was not in the position of a general donor. So, too, with the contributing spouse or partner in the instant case. This person should not have legal control involuntarily wrested from him or her simply because the original purpose of the contribution has been frustrated or rendered unnecessary.

Accordingly, the Commission recommends that, where an unused fertilized ovum has been produced from gametes contributed by a donor who has made an unrestricted donation and one spouse or partner of a couple for whom the ovum was originally intended, legal control over the fertilized ovum should reside in that spouse or partner alone.

---

[235] For a view that control should not reside in a hospital, see Victoria Report on Embryos, *supra*, note 110, para. 2.16, at 31-32.

(d) THE ROLE OF GENDER SELECTION IN THE TRANSFER OF A FERTILIZED OVUM

Persons who use I.V.F. have a right of access to material information at all times, since the principle of informed consent as a continuing condition of medical care underlies I.V.F. no less than any other medical procedure. One piece of relevant information, which now may be obtained prior to implantation,[236] is the gender of the embryo destined to be transferred to the woman. Such information may be sought by a particular woman or couple where it is crucial to the future child's health — for example, where inheritance of a sex-linked genetic trait is involved. Under these circumstances, it may be that the acceptability of a transfer legitimately ought to be dependent upon gender. Indeed, in such a case, it may even be unlawful and unethical to withhold the relevant information.

In other cases, however, it may be urged that the sex of the embryo should be prohibited from being disclosed to potential parents, so that they not have an opportunity to select solely upon the basis of gender. Such selection may be offensive, not least because of a perceived cultural bias in favour of males.

However, even if a case can be made out to deter or prevent gender disclosure in order to limit embryo transfer decisions relating exclusively to gender, enforceable legislation may be impossible to achieve. Moreover, we object to the enactment of legislation that would criminalize or make an offence the inadvertent or indirect disclosure of true information to those who seek it. Accordingly, the Commission recommends that legislation should not be enacted to deal with whether a woman or couple should be entitled to obtain information concerning the sex of a fertilized ovum intended to be transferred to the woman.

(e) RESEARCH AND EXPERIMENTATION ON A FERTILIZED OVUM OUTSIDE THE BODY

(i) General

In chapter 3, the Commission examined the rather skeletal framework of the law pertaining to research and experimentation on human genetic material.[237] We recognized the overlap between therapy, designed to benefit a patient directly (even where the treatment goes beyond traditional medical care to "therapeutic innovation"[238]), and research and experimentation, designed to acquire knowledge irrespective of its direct or immediate application to an individual. However, we noted that the question of pure research and experimentation does arise separately — for example, where embryos are produced but not transferred to a woman — and does provoke serious and growing concerns as medical science increases our control over nature.

---

[236] See the discussion in the Warnock Report, *supra*, note 2, paras. 9.8-9.9, at 50-51.

[237] *Supra*, ch. 3, sec. 7.

[238] Dickens, "What is a medical experiment?" (1975), 113 Can. Med. Ass'n J. 635.

Our review of the present state of the law made it quite clear that very little in the way of legislation, jurisprudence, or professional guidelines[239] now exists in respect of research and experimentation on human genetic material. We also canvassed the controversy in the literature concerning the control of gametes outside the body, a topic considered briefly by the Commission in the present chapter.[240] The issue of control, and the related issues of transfer and abandonment of control, are critical when determining whether, for example, a hospital may conduct research and experimentation on fertilized ova not needed for the purpose of artificial conception.

It seems to be widely recognized that embryonic research is necessary for human welfare, not simply for the development and refinement of the I.V.F. procedure itself. The processes of early embryonic survival and development, and of implantation and subsequent evolution, need to be better understood in order, for example, to reduce the incidence of infertility and to reduce the rate of spontaneous abortion, particularly of genetically normal embryos. Research also needs to be done to reduce abnormal early development of the embryo and implantation failure. The birth of future children by natural and artificial conception may be greatly assisted by knowledge achievable only by research on human embryos. Within the narrow field of I.V.F. practice, research directed to finding a better means of storage and better transfer mechanisms leading to greater success and reduced embryonic wastage is, we believe, appropriate and highly desirable in principle.

While the need for better knowledge is widely recognized, disagreement exists regarding the limits of permissible research. For philosophical, ethical, religious, or other reasons, some persons consider the embryo inviolable from the moment of conception, and no more available for research use without its own full and free consent than a newborn baby or an adult. Others claim that no limits should be imposed, and that research into the uterine environment should be permitted so that, for example, an artificial uterus and placenta may be developed, with the prospect of a full-term infant being created entirely outside the body of a mother. While this has obvious science fiction reverberations and may seem to reflect a greater joy in technology than in humanity, the stated purpose of such research is to save the lives of extremely premature infants, and to preserve their capacities for normal development and functioning by affording them a congenial environment for normal growth. A recent medical report from McMaster University in Hamilton on the poor prospects of extremely low birth-weight infants indicates how much more research needs to be done to assist their survival and capacity to function without physical or intellectual impairment.[241]

---

[239] See, however, the short statement of The Society of Obstetricians and Gynaecologists of Canada, which endorsed the scientific examination of concepti prior to the time development has reached the implantation stage, and which affirmed the need for "a strong research component in any IVF program": see SOGC Statement, *supra*, note 21, at 4.

It has been reported that a committee of the Medical Research Council of Canada is examining research in the context of human artificial conception: see "Ethics rules for research modernized", *The Globe and Mail*, Toronto (July 28, 1984), at 17.

[240] See *supra*, this ch., sec. 4(c)(i).

The Commission is of the view that it is neither necessary nor desirable to impose a total prohibition on research on fertilized ova outside the body. We do recognize the fear of many persons that cloning and "genetic engineering" are but one step removed from less dramatic research and experimentation. However, we do not believe that this view represents the weight of public opinion; nor do we accept the notion that science inherently cannot be controlled and that it must necessarily push beyond frontiers that are ethically acceptable to society. Medical and scientific research and innovation are hardly novel, notwithstanding what appears to be their accelerated rate of development in the second half of this century. Science has, in fact, been the subject of public control for quite some time, and manifestations of occasional aberrant behaviour should not be cited as proof of its inevitable unpredictability and immunity to regulation. Accordingly, the Commission recommends that research and experimentation on a fertilized ovum outside the body should be permitted, subject to the recommendations that follow.

In our view, a formal system of control or regulation must be put in place to govern the institutions permitted to engage in the sensitive area of research and to set the standards by which such institutions may operate. This general acceptance of research on human genetic material, along with a perceived need to guard against unrestricted research on such material — particularly the embryo, with its obvious potential for human life — also find support in the reports from outside Ontario that have considered the subject.[242]

The reports to which reference has been made have tended to discuss two issues in connection with research. One concerns the forum within which research should be conducted; the other relates to the question whether there should be a time limit within which research must take place on a fertilized ovum outside the body. The latter issue will be considered in the separate section that follows, since it relates generally to the length of time a fertilized ovum may be allowed to develop for any purpose, whether research or not. We turn, then, to consider the first-mentioned issue, namely, the appropriate forum for research and experimentation on human embryos.

Few reports from outside Ontario actually make specific recommendations concerning what institutions should or should not be used as research facilities. It would appear, however, that the very nature of embryo research would, at least at the present time, serve to limit the kind and number of institutions that could engage in this practice.

---

[241] See Boyle *et al.*, "Economic Evaluation of Neonatal Intensive Care of Very-Low-Birth-Weight Infants" (1983), 308 New England J. Med. 1330.

[242] See, for example, SOGC Report, *supra*, note 21, at 4; B.M.A. Working Group Report, *supra*, note 39, para. (10), at 1594; M.R.C. Statement, *supra*, note 1, at 1480; and RCOG Report, *supra*, note 48, para. 14.4.6, at 17.

In the reports that have dealt with the matter expressly, one obvious preference has been for the restriction of research to hospitals. For example, one report from the United Kingdom recommended that research on pre-viable fetuses should be conducted in hospitals and with the approval of their ethical review committees. The committee would have to "satisfy itself: (a) on the validity of the research; (b) that the required information cannot be obtained in any other way; and (c) that the investigators have the necessary facilities and skill".[243]

The restriction of research on human embryos to hospitals, or to hospitals and universities, has the clear merit of ensuring a formal means of review by specialists and experts, lay representation, and a degree of public accountability. At present, Ontario universities and a number of teaching hospitals regulate research by means of review committees conforming to the guidelines set forth in the 1980 *Report of the Commission of Inquiry into the Confidentiality of Health Information* (the Krever Report).[244] That Report recommended that research be permitted,[245]

> ... provided that approval has been granted by an appropriate human experimentation committee whose members must not be confined to the principal investigator's discipline and must include one or more representatives of the public, and provided also that that human experimentation committee has been satisfied that the principal investigator has met the following criteria:
>
> (a) the identifiable information sought is indispensable for the purpose of the research project;
>
> (b) the importance of the research project, in the opinion of the committee, justifies the breach of the subject's privacy; and
>
> (c) the principal investigator undertakes [further protection of the subject's interests].

Furthermore, such funding agencies as the Medical Research Council of Canada require ethical approval of research by appropriately composed institutional committees.

It does bear mentioning, however, that institutions other than Ontario universities and teaching hospitals also subscribe to the principles enunciated in the Krever Report. It may be argued, therefore, that, so long as the research facility conforms to certain acceptable ethical, technical, and other guidelines, limiting research to university centres and hospitals is unjustifiably restrictive.

The notion that the critical issue in the regulation of research is the nature and scope of the limits placed on research, and that a restriction on the kinds of place within which research may be conducted is unnecessary, finds support in the report of the Warnock Committee in the United Kingdom.[246] After generally endorsing research on human embryos, the Committee recommended that "research conducted on human *in vitro* embryos and the handling of such embryos should be permitted only under licence".[247] Licences for individual projects and for specified research would be granted by a "new statutory licensing authority to regulate" research and infertility services.[248] This new body would have "substantial lay representation" and the chairman would be a layperson.[249] Research would be tightly controlled, not in terms of the daily activities of the researchers, but by restricting the nature and scope of the projects approved.[250] For example, an applicant, who might be an individual or an institution, would have to establish that "the work is supported by peer review undertaken by appropriate academic referees".[251] Although the Committee did not set guidelines respecting whether an applicant should seek funding before obtaining a licence, it did state that "we consider it crucial that any applicant should have first obtained clearance from the ethical body responsible for such matters in the institution in which he or she wishes to carry out research work before submitting applications".[252]

---

[243] United Kingdom, Department of Health and Social Security, Scottish Home and Health Department, and Welsh Office, *The Use of Fetuses and Fetal Material for Research: Report of the Advisory Group* (1972), paras. 35(3) and (4), at 8.

[244] Krever Report, *supra*, note 169.

[245] *Ibid.*, Vol. III, at 50-51, recommendation 94.

From this brief review of the Warnock Report's examination of research on embryos, it should be noted that the Committee made no mention of the argument that research should be confined to a particular kind of person or institution. It was assumed, apparently, that facilities other than, for example, university medical centres or hospitals, could and should engage in research, so long as they met the standards to be established by legislation and by the proposed new licensing body.

The Commission endorses this view. Necessary research on human embryos should not be the exclusive preserve of universities and hospitals. Indeed, medical research in other areas is not so confined. Excellence in this field may be furthered by the promotion of research by any institution that clearly establishes conformity with appropriate ethical, scientific, and other relevant standards. As we said earlier, the Medical Research Council of Canada has developed guidelines for research — and is now examining guidelines in the context of research on human genetic material — which, while only advisory, are in fact observed by virtually all research institutions in Canada. In addition, review committees operate in hospital and university medical centres. These mechanisms offer a model for the regulatory control of research that may be undertaken by these and other institutions.

The Commission's recommendations in respect of such control are as follows. First, research and experimentation involving a fertilized ovum outside the body should be restricted to research centres approved by the Ministry of Health. Secondly, a research centre should be entitled to be approved only where it has established an ethical review committee for the internal screening of research projects. Thirdly, the Ministry of Health should develop minimum requirements respecting the composition and operation of ethical review committees in research institutions.

---

[246] See, generally, Warnock Report, *supra*, note 2, chs. 11, 12, and 13.

[247] *Ibid.*, para. 11.18, at 64.

[248] *Ibid.*, para. 13.3, at 75.

[249] *Ibid.*, para. 13.4, at 76.

[250] *Ibid.*, paras. 13.10-13.11, at 78.

[251] *Ibid.*, para. 13.11, at 78.

[252] *Ibid.*, para. 13.12, at 79.

It should be noted that the Commission has been silent on substantive ethical and other guidelines that ought to be followed. As a general proposition, we do not believe that this is a matter within our expertise, even if it were assumed that such guidelines could be codified and yet remain sufficiently flexible to permit the evolution of new and better standards. We leave such matters to the Ministry of Health and to the internal ethical review committees.

However, we do wish to enter one caveat to the view expressed above. Notwithstanding our belief that it should be the province of the Ministry of Health and the internal ethical review committees to develop and apply appropriate standards in respect of research projects, we are of the opinion that the law should address expressly certain matters relating to research and experimentation on human embryos. We turn now to consider these matters.

(ii) Transfer of Fertilized Ova Previously Subjected to Research or Experimentation

Earlier in this section, we noted the fears of many persons that research or experimentation on human embryos may be just a prelude to unacceptable "genetic engineering". Related to this issue is the question whether it is ethical to transfer to a woman an embryo that has been the subject of research or experimentation.

As medical science advances, it will become increasingly possible to detect and cure various kinds of abnormality in embryos.[253] One report noted that "[s]uggestions of enhancing embryos through genetic manipulation have been made, as well as suggestions about the treatment of genetic disorders".[254] It is not inconceivable to anticipate a time when the treatment and cure of defects in embryos will have progressed beyond the experimental stage to become therapeutic. At present, however, genetic manipulation and gene therapy cannot be viewed in this light, so that the serious and difficult issues raised in this context are, for the moment at least, highly controversial.

Few reports canvassed by the Commission deal with this particular topic. The ones that do so, however, evince an antipathy to the transfer of embryos that have been subjected to research or experimentation. For example, the B.M.A. Working Group Report observed as follows:[255]

---

[253] See Victoria Report on Embryos, *supra*, note 110, para. 1.14, at 13.

[254] *Ibid.*, para. 1.16, at 14.

[255] *Supra*, note 39, para. (14), at 1594.

> It is not ethically acceptable for medical practitioners to be involved in in vitro fertilisation and embryo replacement procedures in which the gametes (sperm or ova), embryos, or parts thereof are subjected to manipulations, including procedures designed to change their genetic make up or to induce the formation of multiple progeny ('cloning'), if there is any intent to transfer the resulting embryos to a uterus.

It bears emphasizing that the statement of the British Medical Association was directed exclusively to "manipulations" of embryos, where some kind of change was involved, rather than to embryo research generally. The Association's view may be contrasted, then, with that apparently taken by the Warnock Committee. In its Report, the Warnock Committee recommended, without further elaboration, that "no embryo which has been used for research should be transferred to a woman".[256] Earlier, the Committee divided "research" into two categories. The first was "pure research", aimed at increasing and developing knowledge generally; the second was "applied research", that is, among other things, "research with direct diagnostic or therapeutic aims for the human embryo ...".[257] In other words, it appears that the Warnock Committee sought to preclude the transfer of an embryo even where the embryo had undergone "therapeutic" research for its own direct benefit. This prohibition seems to be wider than the one advanced by the British Medical Association.

The most recent report canvassing this topic expressed a division respecting "genetic manipulation" as a means of treating or curing defective embryos that would subsequently be transferred to a woman. The report, from Victoria, stated as follows:[258]

> Some members of the Committee regard developments in genetic manipulation of the kind to which brief reference has been made as leading to real benefits for some couples. Some members have grave reservations about any genetic manipulation, and some prefer to defer their judgment on the matter until a more detailed study of the subject may be completed. The Committee is, however, unanimously of the opinion that the subject of genetic manipulation of untransferred embryos should be carefully studied, and all of the implications of the proposal should be widely canvassed.[259]

The Commission is unanimously of the view, and accordingly recommends, that an embryo that has been the subject of experimentation that has no direct therapeutic purpose in relation to the ovum should not be transferred to a woman. While experimentation on embryos may be essential in order to discover means to alleviate the effects of infertility or genetic impairment, the potential for grave and unacceptable consequences where such embryos are transferred to a woman is too great at the present time. We cannot countenance the use of new and experimental procedures on embryos any more than we can endorse their use on children or adults.

---

[256] Warnock Report, *supra*, note 2, para. 11.22, at 66.

[257] *Ibid.*, para. 11.10, at 61.

[258] Victoria Report on Embryos, *supra*, note 110, para. 1.17, at 14.

[259] While the Committee stated that it was divided on this specific topic, 5 of the 9 members stated that "embryo research [should] be limited to the excess embryos" (*ibid.*, para. 3.26, at 46), that is, presumably those not intended for subsequent transfer to a woman.

The Commission is divided, however, on the propriety of the transfer to a woman of an embryo that has been the subject of therapeutic measures, where the purpose of such procedures is to benefit the embryo directly, for example, to cure a defect or treat an abnormality. Some Commissioners are of the view that no embryo that has been the subject of any manipulation or change, whatever the purpose or result, should be transferred to a woman. They fear that, given the elasticity of the concept of "therapy", permitting so-called therapeutic measures might open the door to techniques that are, in fact, experimental, potentially to the severe detriment of any resulting child. While these Commissioners recognize that infertile or genetically impaired couples might well benefit from "therapeutic" measures of the kind described above, they believe that the present state of medical science is not sufficiently advanced to warrant such measures. Without this treatment, an abnormal embryo would, of course, be wasted. And where the woman whose own ovum was fertilized cannot produce any more ova, the only alternative to childlessness would be the use of donor ova. However, the Commissioners who advocate a total prohibition on the transfer of embryos that have been subjected to any type of research or experimentation are of the view that this possibility must be considered to be a risk or burden necessarily to be borne by the woman in question, at least for the present time.

Conversely, other Commissioners see no reason to preclude the transfer of an embryo that has been the subject of manipulation or change, so long as the measures taken are intended to confer a direct therapeutic benefit on that embryo. These Commissioners believe that medical science has, in fact, advanced sufficiently to the point where some procedures can clearly be characterized as therapeutic, and not purely experimental. Particularly where the intended recipient cannot produce any further ova, it is believed that wastage of a defective embryo that might be successfully treated belies the very purpose and role of medicine and science.

(f) TIME LIMITS ON THE DEVELOPMENT AND STORAGE OF FERTILIZED OVA

In this section, we shall address the question whether a time limit should be imposed in respect of the development of a fertilized ovum outside the body and in respect of the storage of a fertilized ovum by cryopreservation.

Where fertilized ova are produced exclusively for use in an I.V.F. programme, and where all such ova are, in fact, transferred immediately to recipients, the issue of time limits respecting embryonic development and storage does not arise. However, we have seen[260] that, under certain circumstances, there might be "surplus" fertilized ova, initially produced for artificial conception purposes but later not required for transfer to a woman's body. Or a single fertilized ovum might be produced that was to be so transferred but, for some reason, is no longer wanted. How long should such genetic material be permitted to develop? And, where a fertilized ovum is cryopreserved, how long should it be stored?

---

[260] See, generally, *supra*, this ch., secs. 4(a) and (b).

While, as indicated, these questions arise in the context of an I.V.F. programme, they also arise in the context of research and experimentation. Indeed, it is almost exclusively in respect of research and experimentation that the many committees that have reviewed the issue have dealt with time limits beyond which embryos should not be allowed to develop or to be stored.

Undoubtedly, public concern respecting research and experimentation on human embryos relates primarily to generalized fears that embryos will be used for what has been pejoratively called "genetic engineering", or perhaps more accurately, "eugenics", involving cloning, selective breeding, and so on. It is, in part, to allay these anxieties that so many committees and agencies have recommended a time limit beyond which an *in vitro* embryo should not be allowed to develop or to be stored.

The Warnock Committee, as well as others, have recognized that, biologically, any particular time limit would be arbitrary, given the continuous process of embryonic development from stage to stage.[261] The Committee canvassed the "wide range of opinion on this question".[262] Having regard to the importance of the subject, the Committee's discussion of the differing views is reproduced here:[263]

> One argument put forward may be termed the strictly utilitarian view. This suggests that the ethics of experiments on embryos must be determined by the balance of benefit over harm, or pleasure over pain. Therefore, as long as the embryo is incapable of feeling pain, it is argued that its treatment does not weigh in the balance. According to this argument the time limit for *in vitro* development, and for research on the embryo, could be set either when the first beginnings of the central nervous system can be identified, or when functional activity first occurs. If the former is chosen, this would imply a limit of twenty-two to twenty-three days after fertilisation, when the neural tube begins to close. As to the latter, in the present state of knowledge the onset of central nervous system functional activity could not be used to define accurately the limit to research, because the timing is not known; however, it is generally thought to be considerably later in pregnancy. With either limit, proponents suggest subtracting a few days in order that there would be no possibility of the embryo feeling pain.
>
> The Royal College of Obstetricians and Gynaecologists suggested that embryos should not be allowed to develop *in vitro* beyond a limit of seventeen days, as this is the point at which early neural development begins. The British Medical Association favoured a limit of fourteen days and a number of groups, including the Medical Research Council and the Royal College of Physicians suggested that the limit should be at the end of the implantation stage. Again, some groups submitting evidence suggested that no embryo which had gone beyond the beginning of the implantation stage should be used for research.

---

[261] Warnock Report, *supra*, note 2, para. 11.19, at 65.

[262] *Ibid.*, para. 11.20, at 65.

[263] *Ibid.*, paras. 11.20-11.21, at 65.

Ultimately, the Warnock Committee chose as its initial point of reference the formation of the "primitive streak", at about fifteen days after fertilization, which "marks the beginning of individual development of the embryo"; the Committee then took an earlier date — fourteen days after fertilization — "as a desirable end-point for research". However, this fourteen day period "does not include any time during which the embryo may have been frozen".[264]

The Commission recognizes that the setting of any time limit is unavoidably arbitrary, and might sacrifice therapeutic and social benefits that likely could be obtained from research on embryos developing beyond that limit. For example, the limit proposed in the Warnock Report would preclude critical studies of implantation failure.[265] Accordingly, it has been argued that a somewhat longer period of time for research may be desirable in an attempt to reduce the rate of spontaneous abortion.

Just as the Commission endorses the view that artificial conception services, properly regulated, should be offered to infertile persons, it believes that research on human embryos should be encouraged in order to further our knowledge of embryonic development so that all persons, fertile and infertile, might benefit. However, there are certain limits, sometimes arbitrarily chosen, with which our society believes it must live. Notwithstanding the promise of unfettered scientific research, the public is equally concerned with its potential curses. While welcoming continued research and development, we believe such concern to be rationally based and worthy of respect. Accordingly, the Commission recommends that, having regard to the information now available to medical science respecting embryonic development, regulations should provide that no fertilized ovum outside the body should be allowed to develop beyond fourteen days after fertilization. Should the state of medical knowledge at some future date indicate that the fourteen day period is inappropriate, by being either too short or too long, the regulations could easily be amended.

We turn now to consider whether there should be an outside limit beyond which a fertilized ovum should not be cryopreserved or otherwise stored. While, in most cases, embryos are stored by couples who might wish further children or who might need further embryos if the initial I.V.F. treatment has proved unsuccessful, they may be stored anonymously by a gamete bank or stored specifically for research purposes.

Whatever the impetus for storage, we agree in principle with the Warnock Committee that there should be "a definite time limit set to the storage of embryos both because of the current ignorance of the possible effects of long storage and because of the legal and ethical complications that might arise over disposal of embryos whose parents have died or divorced or otherwise been separated".[266]

---

[264] *Ibid.*, para. 11.22, at 66. We shall deal with storage later in this section.

[265] There is evidence that, in nature, 62% of embryos are lost prior to 12 weeks of pregnancy: see Edmonds *et al.*, *supra*, note 224.

[266] Warnock Report, *supra*, note 2, para. 10.10, at 56.

The Warnock Committee recommended "a maximum of ten years for storage of embryos after which time the right to use or disposal should pass to the storage authority".[267] Presumably, the storage authority could then waste the embryo or donate it for the purpose of artificial conception or, perhaps, research. In other words, where the embryo is donated, some further period of use, however short, would seem to have been contemplated.

While the Commission has no great antipathy to the scheme propounded in the Warnock Report, on balance we do not wish to give the storage authority the right to donate the embryo to another couple or to a research institution. We are of the view that storage after ten years should not be permitted. The situation at the end of the ten year storage period differs from the situation where the couple die or cannot agree on the disposition of the embryo. In those cases, we proposed that the person or facility in actual possession of the embryo should have the right to determine the embryo's fate.[268] We did so because there would be no reasonable alternative to giving such control to that person or facility. However, where, at the end of the ten year storage period, the couple is simply silent, giving no directions to the storage authority, we are willing to presume that they do not wish the fertilized ovum to be donated for any purpose.

Accordingly, we recommend that there should be a maximum of ten years for the cryopreservation or similar storage of a fertilized ovum, after which time the storage authority should be under a duty to have the ovum wasted.

(g) THE CRYOPRESERVED FERTILIZED OVUM AND THE RULE AGAINST PERPETUITIES

A rather esoteric and legalistic point arises in estate planning, concerning whether a testator should be able to bind property by relation to the birth of a child from an embryo in cryostorage at the time of the testator's death. The issue relates, then, to the purpose and incidents of the rule against perpetuities, which is designed to prevent estates from being rendered inalienable for excessive periods of time.

One option is to leave the issue to be determined by the courts, bearing in mind existing legal doctrine on the rule against perpetuities.[269] Alternatively, legislation might expressly provide that a cryostored embryo is not to be considered "a life in being" from the existence of which the relevant time periods run. This might be done in exclusionary language, but might be achieved more elegantly through a provision that "a life in being" does not exist before an unborn child is *en ventre sa mere*. A further alternative is simply to enact that a cryostored fertilized ovum is "a life in being" for the purpose of the rule against perpetuities.

---

[267] *Ibid.*

[268] See *supra*, this ch., sec. 4(c).

[269] See, for example, *Perpetuities Act*, R.S.O. 1980, c. 374.

The Commission has reservations concerning whether an embryo in cryostorage would or should be considered "a life in being" for purposes of the rule against perpetuities. However, we are of the view that no legislated policy is called for on the issue, which is rather unlikely to present major difficulties. Instead, we believe that judicial resolution of the matter is appropriate.

5. PROPOSALS RELATING TO SURROGATE MOTHERHOOD

(a) INTRODUCTION

The term "surrogate motherhood" does not refer to a distinct type of artificial conception technology. Surrogate motherhood involves the application of one of the artificial conception technologies that we have discussed in order to produce an infant who, pursuant to an antecedent arrangement, will be surrendered at birth by the gestating mother to another person to raise as his or her own child. Thus, what distinguishes surrogate motherhood from the other artificial conception technologies is not the technology itself, but the special circumstances of its employment.

Recalling the artificial conception technologies, the following kinds of surrogate motherhood arrangement are possible:

1. a woman is artificially inseminated *in vivo* by sperm of a donor and, upon birth, custody of the child is surrendered to the sperm donor;
2. a woman's extracted ovum is fertilized *in vitro*, the embryo is transplanted into the uterus of another woman who is able to bear a child and, upon birth, the child is surrendered to the ovum donor;
3. a woman is fertilized *in vivo*, the embryo is flushed from her by means of lavage and transplanted into the uterus of another woman who is able to bear a child and, upon birth, the child is surrendered to the ovum donor; and
4. a woman's ovum is fertilized *in vitro*, or *in vivo* followed by recovery through lavage, and transplanted into the uterus of a second woman and, upon birth, the child is surrendered to a third person, such as the sperm donor and his wife.

In addition to the circumstances described above, a surrogate motherhood arrangement may be sought where, in the case of ovum donation by means of *in vivo* fertilization and lavage, an inadvertent failure of the lavage procedure results in pregnancy. The intended ovum donor then may choose to gestate the fertilized ovum for the purpose of surrendering the infant to the person who had been the intended recipient of the fertilized ovum.[270]

A surrogate motherhood arrangement involves an agreement between the woman who is to bear the child and the persons who are to receive it to raise as their own. While a variety of terms may be agreed upon by the parties, the heart of any arrangement is a promise on the part of the surrogate mother to undergo the medical procedure necessary to achieve a pregnancy and to surrender custody of the child irrevocably upon birth, and a reciprocal promise on the part of the other party or parties to accept the child. Such an arrangement may involve a payment to the surrogate mother by the intended parents in return for the fulfilment of her promises. However, some women do volunteer to bear a child for reasons of altruism.

---

[270] See discussion *infra*, this ch., sec. 5(e)(vii)a.

Recourse to a surrogate motherhood arrangement may be sought where a couple suffers from an infertility problem that cannot be circumvented by other means. In the case of certain uterine problems, such as where the uterus is abnormal or absent, the artificial conception techniques that we have reviewed will be to no avail. Indeed, the problem is not one of conception at all, but of an inability to carry the fetus to term, which could be caused, for example, by implantation difficulties or chronic spontaneous abortion. For couples with such problems, a surrogate motherhood arrangement presents the only means of having a child who is genetically related to one of them, and possibly both.

But, while surrogate motherhood may be employed as a solution to infertility, it may also be sought in less exigent circumstances. A fertile woman may prefer that another woman carry a child for her in order to avoid pregnancy, possibly for reasons of career or vanity. That artificial conception technology might be so used raises questions respecting the grounds of eligibility for services, an issue that will be discussed at a later stage in this chapter.[271] At this juncture, we wish only to indicate that a nonmedical motivation may underlie recourse to this alternative.

Not surprisingly, surrogate motherhood has generated substantial controversy wherever it has been considered. A procedure that has as its essence the deliberate creation of a child exclusively for the purpose of surrendering the child permanently to the care of another is a striking departure from our collective accumulated experience. For some, this procedure directly challenges basic normative assumptions about the family. It is for this reason that the surrogate motherhood alternative warrants careful attention. But the understandably deep emotional feelings associated with surrogate motherhood, while deserving of respect, should not displace the balanced, reasoned analysis that is crucial to the development of recommendations within our Terms of Reference.

As discussed in chapter 3, the present law in Ontario, rooted securely in a world of natural reproduction, has not addressed the surrogate motherhood alternative directly. As with the artificial conception technologies, certain aspects of the existing law do apply fortuitously to these arrangements and may serve, to some extent, to resolve questions of status and to define the rights of the parties. Since we have examined the present law in detail in chapter 3,[272] we shall review only briefly, at this stage, its effect on surrogate motherhood arrangements.

---

[271] See discussion *infra*, this ch., sec. 5(e)(i)a.

[272] See discussion *supra*, ch. 3, sec. 8.

At the outset, it should be noted that surrogate motherhood arrangements are not prohibited by statute, except to the extent that they may violate section 67 of the *Child Welfare Act*,[273] which proscribes payments in connection with the adoption of a child. Although not otherwise prohibited, it would appear that such arrangements are illegal and unenforceable at common law as being against public policy. Hence, any purported transfer of parental rights and responsibilities by a surrogate mother to another pursuant to an agreement would have no legal effect whatsoever. For all purposes, the surrogate mother would remain the mother in law and would have the attendant rights and responsibilities.

Moreover, should a party fail to honour his or her promises, the agreement would not be enforceable at the behest of the other party. If the surrogate mother were to refuse to transfer custody of the child to the persons who sought to raise the child, a court would not compel her to do so. Nor, where custody of the child has been transferred, could the intended social parents be compelled to make the promised payment.

In the event of a dispute over the custody of a child, while neither party could seek the assistance of the court on the basis of their agreement, each could apply for custody under the *Children's Law Reform Act*. As with any custody determination, the issue would be determined according to the best interests of the child.

Although the present law does not facilitate the achievement of the parties' objectives as a matter of contract law, where the husband is the biological father of the child the parties may utilize existing procedures to realize the same end. If the surrogate mother and the couple wishing to raise the child are in agreement, procedures under the *Children's Law Reform Act* may be employed in order to establish paternity in the husband and to transfer custody to the couple. Following completion of these procedures, an application for a step-parent adoption under Part III of the *Child Welfare Act*[274] may be made in order to sever the connection between the surrogate mother and the child as a matter of law, and to constitute the wife as the mother of the child for all legal purposes. It bears emphasizing that, although this circuitous route will culminate in a result identical to that sought to be achieved by contract, the court will be involved in determining custody and, later, the status of the child according to the best interests of that child, which may not necessarily conform to the intentions expressed in the agreement between the adult parties.

As we stated in chapter 3, the fact that recourse to the existing statutory framework may culminate in a judicial determination consistent with the intentions of the parties should not be construed as an appropriate response to surrogate motherhood. The method that we have described is circuitous and cumbersome. To the extent that it involves an *ex post facto* reaction to the birth of the child, rather than dealing with the issues prior to birth, or even conception, the statutory framework may balance the competing interests inadequately. Moreover, it should be obvious that the utility of the existing procedures depends entirely on the cooperation of the surrogate mother. Should she resile from her promise to transfer the child, a custody dispute would ensue, which would be extremely disruptive to the child and the adult parties. Finally, it should be observed that the procedures that we have mentioned may only be set in motion where the intended social father is also the biological father. Where semen has been donated, an order for paternity, which would constitute the basis for the application for custody, cannot be obtained by the social father.

---

[273] *Supra*, note 41. See, also, the *Child and Family Services Act, 1984*, *supra*, note 41, s. 159.

[274] See, also, the *Child and Family Services Act, 1984*, *supra*, note 41, Part VII.

In chapter 3, we concluded that the existing law has not adequately met the challenge presented by the advent of the artificial conception technologies. This conclusion applies with even greater force in the case of surrogate motherhood, with the result that all persons potentially affected by such an arrangement are at risk. We are of the view that such risks should not be tolerated with equanimity, but should be addressed directly by legislation.

In this connection, we observe that the General Council of the Canadian Medical Association has approved a resolution "[t]hat the CMA alert the physicians of Canada to the number and complexity of unresolved legal problems relating to surrogate motherhood and to advise them to become associated with the procedure only with great caution until its legal, social and psychological implications are clarified".[275]

In chapter 4 of this Report, we discussed the alternative approaches to law reform, contrasting a "private ordering" approach with a "state regulation" approach. We explained that the former is a facultative regime that enables individuals to arrange their affairs as they see fit, without imposing normative constraints on the exercise of choice, and that the latter limits individual choice in the interest of realizing perceived public values. We observed that, where state regulation is thought desirable, it may take the form of either prohibition or regulation of the activity in question.

We have already concluded that the inadequacy of the response of the present law to surrogate motherhood warrants intervention on the part of the Legislature. The question then becomes the form that such intervention should take. In considering this difficult question, we have examined the experience in other jurisdictions and weighed carefully the various policy arguments.

(b) APPROACHES IN OTHER JURISDICTIONS

Our survey of other jurisdictions reveals that legislation has been enacted specifically to address surrogate motherhood only in the State of Victoria in Australia.[276] Elsewhere, as in Ontario, statutes designed to deal with other matters may inadvertently affect such arrangements. Moreover, some case law has arisen in connection with surrogate motherhood arrangements.

---

[275] Canadian Medical Association, *Proceedings of the 116th Annual Meeting, Including the Transactions of General Council* (1983), at 128, resolution 83-23.

[276] See discussion *infra*, this sec.

In England, the Family Division of the High Court of Justice was faced with an application for access by the natural father in an abortive surrogate motherhood arrangement.[277] In his *obiter* remarks, Mr. Justice Comyn stated that he regarded the "pernicious agreement" as a purported contract for the purchase and sale of a child, and therefore void as against public policy.

In the United States, attempts by parties to use existing legislation to achieve the objectives of surrogate motherhood agreements thus far have been unsuccessful.[278] On the the other hand, a Kentucky court has refused an application by the state Attorney General to revoke the corporate charter of a private surrogate motherhood agency.[279] The Attorney General argued that the activities of the agency violated statutory proscriptions that had been enacted in connection with adoption. The Court held that the legislation did not apply to these activities.

While there has been a dearth of case law respecting surrogate motherhood, this subject has received attention from legislators, law enforcement officials, and government and other bodies.

Certain state Attorneys General have issued advisory opinions respecting whether surrogate motherhood activities would run afoul of either public policy or existing statutory provisions governing the placement of children for adoption. One of these has concluded that the practice is contrary to public policy as being tantamount to an agreement for the purchase and sale of a child.[280] With respect to the conformity of surrogate motherhood arrangements to existing legislation, other opinions suggest that their legality depends on the precise language of the relevant statute.[281]

In response to the establishment of private surrogate motherhood agencies, governmental studies have been conducted in several states.[282] In at least ten American states, draft bills have been introduced. Not a single statute has been enacted, however, and almost all the bills have been allowed to die in committee. While a few bills have sought to prohibit surrogate motherhood,[283] the majority have proposed regulatory schemes of varying complexity. The regulatory proposals range along a continuum from simply stipulating the minimum terms that must be included in an agreement[284] to a formal adoption model that requires a judge to attest to the suitability of the natural father and his wife before a physician can lawfully perform artificial insemination of the surrogate mother.[285]

---

[277] *A. v. C.*, unreported (June 20, 1978, H.C.J., Fam. Div.). For a brief discussion of this case, see Cusine, "Womb-leasing: Some Legal Implications" (1978), 128 New L.J. 824. The decision was affirmed on appeal: see *A. v. C.*, unreported (July 18, 1978, C.A.). While neither decision is reported, Mr. Justice Comyn's decision is summarized in [1978] Family Law 170.

[278] See *In re Baby Girl*, unreported (March 18, 1983, Jefferson Co. Cir. Ct., Ky.); *Doe v. Kelley*, unreported (January 28, 1980, Wayne Co. Cir. Ct., Mich.), aff'd 106 Mich. App. 169, 307 N.W. 2d 438 (1981); and *Syrkowski v. Appleyard*, unreported (November 25, 1981, Wayne Co. Cir. Ct., Mich.), aff'd 122 Mich. App. 506, 333 N.W. 2d 90 (1983). See, also, *In the Petition of R.K.S. for Adoption*, unreported (April 13, 1984, Sup. Ct., Fam. Div., D.C.).

[279] See *Commonwealth of Kentucky, ex rel. Beshear v. Surrogate Parenting Associates, Inc.*, unreported (October 26, 1983, Franklin Co. Cir. Ct., Ky.). The decision is under appeal to the Kentucky Court of Appeals.

[280] See Kansas Att. Gen. Op. No. 82-150 (July 2, 1982).

[281] See Ohio Att. Gen. Op. No. 83-001 (January 3, 1983), and Oklahoma Att. Gen. Op. No. 83-162 (September 29, 1982). The opinion issued by the Attorney General for Kentucky — Ky. Att. Gen. Op. No. 81-18 (January 26, 1981) — which constituted the basis for its action against Surrogate Parenting Associates, Inc., was rejected by the Court in *Commonwealth of Kentucky, ex rel. Beshear v. Surrogate Parenting Associates, Inc.*, *supra*, note 279.

In recent years, various bodies in the United Kingdom, Australia, and the United States have examined surrogate motherhood arrangements. The majority of these bodies have indicated their opposition to these arrangements and have urged measures to discourage persons from entering into them.

In the United Kingdom, the most comprehensive discussion of the issue can be found in the Report of the Warnock Committee.[286] A majority of the Warnock Committee was opposed to the practice of surrogate motherhood. In order to discourage its use, the following recommendations were made:[287]

> 56. Legislation should be introduced to render criminal the creation or the operation in the United Kingdom of agencies whose purposes include the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wish to utilise the services of a carrying mother; such legislation should be wide enough to include both profit and non-profit making organisations.
>
> 57. Legislation should be sufficiently wide enough to render criminally liable the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy.
>
> 58. It [should] be provided by statute that all surrogacy agreements are illegal contracts and therefore unenforceable in the courts.

Before making these recommendations, the Warnock Committee considered the arguments for and against surrogate motherhood.[288] It concluded as follows:[289]

---

[282] See, for example, Virginia, *Report of the Department of Welfare Study Committee on Surrogate Parenthood to the Senate Committee on Rehabilitation and Social Services and the House Committee on Health, Welfare and Institutions* (October, 1981), and Maryland, *Report of the Committee to Study Surrogate Mother Programs in Maryland* (February, 1983), and *Surrogate Mothering Programs in Maryland: A Study Conducted by Staff of the Department of Human Resources* (August, 1983). The General Assembly of Pennsylvania has passed a resolution providing for the appointment of a special committee to investigate surrogate parenting: see House Resolution No. 109 (June 21, 1983).

[283] See, for example, AB 3139 (New Jersey), and SB 63 (Michigan).

[284] See, for example, A6624 (New York).

[285] See, for example, H2098 (South Carolina). See, generally, Comment, "Surrogate Motherhood: Contractual Issues and Remedies under Legislative Proposals" (1984), 23 Washburn L.J. 601.

[286] See Warnock Report, *supra*, note 2.

[287] *Ibid.*, at 85-86. See, also, *ibid.*, paras. 8.18-8.19, at 46-47.

> The moral and social objections to surrogacy have weighed heavily with us. In the first place we are all agreed that surrogacy for convenience alone, that is, where a woman is physically capable of bearing a child but does not wish to undergo pregnancy, is totally ethically unacceptable. Even in compelling medical circumstances the danger of exploitation of one human being by another appears to the majority of us far to outweigh the potential benefits, in almost every case. That people should treat others as a means to their own ends, however desirable the consequences, must always be liable to moral objection. Such treatment of one person by another becomes positively exploitative when financial interests are involved. It is therefore with the commercial exploitation of surrogacy that we have been primarily, but by no means exclusively, concerned.

Two members of the Warnock Committee dissented from the recommendations set out above. They suggested that rather than prohibit the practice, "the door [should] be left slightly ajar so that surrogacy can be more effectively assessed".[290] It was the view of the minority that the licensing authority, which the Committee had recommended generally to regulate artificial conception services, should be empowered to license an agency or agencies to arrange surrogate mother births.[291] It believed firmly that, since the issues involved in surrogate motherhood were similar to those associated with adoption, commercial agencies should be prohibited. In order to allow the couple wishing to raise the child to have the status of parents, the dissenting members suggested that a form of adoption procedure be made available. Finally, they disagreed that surrogate motherhood agreements should be declared by statute to be illegal contracts, preferring to leave the issue to the courts.

The position of the dissenting minority followed from its conclusion that it was premature "to close the door completely on surrogacy being offered as a treatment for childlessness".[292] A particular concern was that, if the demand for this alternative were to continue or to expand, one consequence of the recommendation preventing professionals from providing assistance would be that couples might undertake self-help measures and thereby not receive the necessary medical and counselling services.[293]

---

[288] *Ibid.*, paras. 8.10-8.16, at 44-46.

[289] *Ibid.*, para. 8.17, at 46.

[290] *Ibid.*, para. 9, at 89.

[291] In this regard, the minority explained as follows (para. 5, at 88):

> These arrangements would include the matching of commissioning parents with surrogate mothers, and the provision of adequate counselling to ensure that the legal and personal complications of surrogacy were fully understood. The only agencies which could be licensed would be those in which child-caring skills were well represented and in which there was no commercial motive. Thus adoption and fostering agencies or some new agency, similarly staffed and run, could be appropriate candidates for licensing. We are not suggesting that the licensing authority establish an agency, only if one is proposed it be empowered to consider its application. Access to a licensed agency could only be by referral from a consultant gynaecologist.

[292] *Ibid.*, para. 5, at 88.

The Law Society of England, in its submission to the Warnock Committee,[294] stated that "womb leasing for which payment is made" is "thoroughly undesirable".[295] The Law Society speculated as to whether the time was propitious to render criminal those practices associated with commercial surrogate motherhood arrangements. Interestingly, the submission of the Law Society of Scotland[296] seemed to indicate that surrogate motherhood would be an appropriate alternative if there was a medical reason for recourse to the procedure and an adoption procedure was to establish the relationship between the child and the couple who wished to raise it. The submission also approved payment of the reasonable expenses of the surrogate mother, including "appropriate" compensation for loss of employment, and possibly other payments as well.[297]

Independent of the Warnock Committee inquiry, certain medical bodies in Great Britain have considered the propriety of employing surrogate motherhood arrangements in the context of *in vitro* fertilization. Both the Working Group on Human In Vitro Fertilisation, established by the British Medical Association Council,[298] and the Ethics Committee of the Royal College of Obstetricians and Gynaecologists[299] have indicated their rejection of this reproductive alternative. The position of the Working Group on In Vitro Fertilisation was not supported by articulated reasoning.[300] By contrast, the conclusion of the Ethics Committee of the Royal College, that it was "unethical to implant embryos conceived by IVF into surrogate mothers",[301] was based, in part, on concerns about the psychological impact on the child and the surrogate mother.[302]

Finally, the Council of the British Medical Association has approved a resolution stating that, "in consideration of the difficulties, anxieties, and uncertainties to all individuals concerned ... it is unethical for a doctor to become involved in techniques and procedures leading to surrogate motherhood".[303] This resolution represents the official policy of the British Medical Association.

---

[293] *Ibid.*, para. 4, at 88.

[294] England, The Law Society, *Memorandum by the Society's Standing Committee on Family Law: Human Fertilisation and Embryology* (1983).

[295] *Ibid.*, para. 2.6, at 3.

[296] Law Society of Scotland Report, *supra*, note 37.

[297] *Ibid.*, at 12.

[298] B.M.A. Working Group Report, *supra*, note 39.

[299] RCOG Report, *supra*, note 48.

[300] B.M.A. Working Group Report, *supra*, note 39, para. 13, at 1594.

[301] RCOG Report, *supra*, note 48, para. 7.6, at 8.

[302] *Ibid.*, paras. 7.2-7.3, at 7-8.

[303] British Medical Association, "Annual Report of Council 1983-4" (1984), 288 Brit. Med. J. 25 (hereinafter referred to as "B.M.A. Annual Report").

Recently, the Council for Science and Society[304] in the United Kingdom released a report prepared by an *ad hoc* Working Party on the ethical aspects of the new artificial conception techniques.[305] After acknowledging that there was "a strong presumption against 'surrogate motherhood' ",[306] arising from concerns about the psychological effect on the surrogate mother and, to a lesser extent, the child, and the possibility of commercialization, the Working Party concluded that " 'surrogate motherhood' should not be prohibited by law".[307] It observed that "the procedure *might* be justifiable in very exceptional circumstances".[308] The Working Party suggested that, if the procedure were ever used, adequate counselling of the parties should be assured, and the surrogate mother should be selected carefully on the basis that she will conduct herself with care during the pregnancy. Interestingly, the Working Party took the view that, if the woman were to refuse to surrender the child, she should not be forced to do so.

In the United States, surrogate motherhood has excited some concern within the medical community, due perhaps to the proliferation of private agencies offering this service. In 1983, both the American Medical Association (A.M.A.) and The American College of Obstetricians and Gynecologists articulated their positions. In its Statement of Policy, "Ethical Issues in Surrogate Motherhood",[309] The American College of Obstetricians and Gynecologists expressed "significant reservations about this approach to parenthood". Notwithstanding the identification of several specific ethical concerns associated with surrogate motherhood arrangements, the College took the view that the decision to participate should be left to the conscience of individual physicians. However, certain guidelines were suggested in the Statement of Policy. Among these was an enjoinder that "[t]he physician should not participate in a surrogate program where the financial arrangements are likely to exploit any of the parties".

The A.M.A. has taken an entirely different view of this matter. In December, 1983, the House of Delegates of the A.M.A. adopted a report of the Judicial Council,[310] which concluded that " 'surrogate mother' arrangements do not provide a satisfactory reproductive alternative". The Report alluded generally to "many ethical, legal, psychological, societal and financial concerns". In particular, it referred to the possibility of a "defective child", psychological risks to the surrogate mother, and difficulties attendant upon abortion and refusal to surrender the child. Apart from brief mention of these concerns, however, the Judicial Council did not support its disapproval with a detailed discussion.

---

[304] The Council for Science and Society is a registered charity, formed in 1973. Its object is to promote "the study of, and research into, the social effects of science and technology, and of disseminating the results thereof to the public".

[305] Council for Science and Society, *Human Procreation — Ethical Aspects of the New Techniques* (1984).

[306] *Ibid.*, at 50.

[307] *Ibid.*, at 51.

[308] *Ibid.* (emphasis in original). It stated that "[i]t might be considered justifiable only when a couple have a physical inability to have a child in any other way, and never for purposes of convenience" (*ibid.*, at 51).

[309] The American College of Obstetricians and Gynecologists, "Ethical Issues in Surrogate Motherhood", in ACOG Statement of Policy (May, 1983) (hereinafter referred to as "ACOG Policy Statement").

[310] American Medical Association, *Judicial Council Report (I-83)* (1983).

In Australia, opposition also has been expressed to the use of surrogate motherhood arrangements in several reports and, in the State of Victoria, prohibitory legislation has been enacted. In a recent Report,[311] a Committee appointed by the Queensland government recounted the usual objections to surrogate motherhood and then commented that "the most prudent course would seem to be to leave such agreements unenforceable, at least until experience demonstrates whether regulation of such agreements is required in the interest of society and of the parties involved".[312] The Committee considered "that it would not be desirable, at least at present, to make surrogacy arrangements criminal offences, and that lack of enforceability of surrogacy contracts will probably suffice to prevent the widespread encouragement of surrogate motherhood arrangements".[313] It envisaged that, if questions respecting parental rights and obligations, including custody and status, arose, they would be decided in custody or other proceedings under the general law.[314] The Committee did conclude, however, "that it should be made illegal to advertise to recruit women to undergo surrogate pregnancy, or to provide facilities for persons who wish to make use of the services of such women".[315] Finally, the Queensland Committee recommended that the Royal Australian College of Obstetricians and Gynaecologists should address, from a medical perspective, the ethical problems raised by surrogate motherhood.

Recently, the Victoria Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization published its *Report on the Disposition of Embryos Produced by In Vitro Fertilization.*[316] The Committee recommended "that surrogacy arrangements shall in no circumstances be made at present as part of an IVF programme in Victoria".[317] The Committee opposed both commercial surrogate motherhood arrangements and gratuitous arrangements, but reserved its harsher criticism for the former, which it characterized as "inhuman".[318]

The opposition of the Victoria Committee to commercial surrogate motherhood agreements followed from its view that such agreements involved the buying and selling of infants.[319] With respect to strictly voluntary arrangements, where there is no element of commerce,[320] the Committee expressed two practical concerns: first, conflicts might arise over custody in the event of a refusal by the surrogate mother to surrender the child; and secondly, a defective child might be rejected by the couple who had initially wanted a child.[321] On a more fundamental level, some members of the Committee were troubled about "the deliberate manufacture of a child for others".[322]

---

[311] Queensland Report, *supra*, note 2.

[312] *Ibid.*, at 116.

[313] *Ibid.*, at 117.

[314] However, the Committee did recommend that "any doubt which may exist that the woman who gives birth to a child is considered to be its mother, should be removed by legislation which so provides an irrebutable presumption": *ibid.*, at 118.

[315] *Ibid.*

[316] Victoria Report on Embryos, *supra*, note 110.

[317] *Ibid.*, para. 4.17, at 54.

[318] *Ibid.*, para. 4.11, at 52.

In November, 1984, the Legislative Assembly of Victoria enacted the *Infertility (Medical Procedures) Act* 1984.[323] Although concerned primarily with the regulation of artificial conception technologies and, in particular, *in vitro* fertilization, the Act does address surrogate motherhood. It seeks to discourage the practice by enacting certain prohibitions in relation to it and by providing that a surrogate motherhood agreement is void.

The Act defines a surrogate mother very broadly:

> 30.-(1) In this section, a reference to a woman who acts, or agrees with another person or other persons to act, as a surrogate mother is a reference to a woman who has entered into, or enters into, a contract, agreement or arrangement with that other person or those other persons, whether formal or informal, and whether or not for payment or reward under which the woman agrees —
>
> (a) to become pregnant, or to seek or attempt to become pregnant, with the intention that a child born as the result of the pregnancy become and be treated, whether by adoption, agreement or otherwise, as the child of that other person or of those other persons; or
>
> (b) being pregnant, that a child born as the result of the pregnancy become and be treated, whether by adoption, agreement or otherwise, as the child of that other person or those other persons.

It should be noted that this definition does not restrict the meaning of "surrogate mother" to a woman who is pregnant, or who seeks to become pregnant, by means of artificial conception. Thus, it appears to embrace a woman whose pregnancy is a consequence of sexual intercourse.

The *Infertility (Medical Procedures) Act* 1984 prohibits three types of conduct in relation to surrogate motherhood arrangements. First, it prohibits the publication of a statement, advertisement, notice or other document that is intended or likely to induce a person to agree to act as a surrogate mother, that seeks a woman willing to agree to act as a surrogate mother, or that states or implies that a woman is willing to agree to act as a surrogate mother.[324] This prohibition applies irrespective of payment.

---

[319] *Ibid.*

[320] The Committee, it should be noted, stated that "[a]n arrangement that such a woman's medical, hospital and travelling expenses be paid would not result in it being labelled as commercial": *ibid.*, para. 4.12, at 53.

[321] *Ibid.*, paras. 4.14-4.15, at 53-54.

[322] *Ibid.*, para. 4.16, at 54.

[323] *Supra*, note 48.

Secondly, the Act provides that "[a] person shall not ... make, give or receive, or agree to make, give or receive, a payment or reward for or in consideration of the making of a contract, agreement or arrangement under which a woman agrees to act as a surrogate mother".[325] This would appear to proscribe the offering or payment of money by a couple seeking a child and the remunerative activities of intermediaries seeking to arrange surrogate motherhood agreements.

Thirdly, the Act provides that "[a] person shall not ... receive or agree to receive a payment or reward in consideration for acting, or agreeing to act, as a surrogate mother".[326]

Violation of any of these prohibitions may lead to a penalty of imprisonment for two years. In addition to discouraging surrogate motherhood by these prohibitions, the Act provides that "[a] contract or agreement (whether made before or after the commencement of this section) under which a woman agrees with another person or other persons to act as a surrogate mother is void".[327]

Finally, mention should also be made of the Report of the South Australia Working Party on In Vitro Fertilization and Artificial Insemination by Donor.[328] In that Report, the Working Party recommended "that there should be no change to the law to enable surrogacy to be practised ... and that a policy should be formally adopted by the Government in relation to the *Adoption of Children Act* to prevent surrogacy being practised ...".[329] The Working Party was of the view that "[t]he community in general regards surrogacy as unacceptable". Despite its breadth, this assertion was supported by very few specific concerns. Attention was drawn to the "serious emotional consequences" to a couple and "bitter litigation" that might ensue if the surrogate mother were to refuse to surrender the child. The Working Party also observed that the contract would likely be regarded as contrary to public policy and unenforceable.[330]

(c) POLICY IN PRINCIPLE

From the foregoing discussion, it is apparent that a considerable body of informed opinion in the United Kingdom, Australia, and the United States has, at the very least, serious reservations about the practice of surrogate motherhood. In some of the reports, however, we observe that opposition to the practice is expressed without supporting reasoning, as if the impropriety of this reproductive alternative were self-evident. In others, the particular concerns are articulated expressly, and it is to these arguments that we turn now in order to decide between prohibition and regulation.

---

[324] *Ibid.*, s. 30(2)(a).

[325] *Ibid.*, s. 30(2)(b).

[326] *Ibid.*, s. 30(2)(c).

[327] *Ibid.*, s. 30(3).

[328] South Australia, *Report of the Working Party on In Vitro Fertilization and Artificial Insemination by Donor* (1984).

[329] *Ibid.*, at 29.

[330] *Ibid.*

Several of the most commonly expressed arguments centre around the fact that surrogate motherhood arrangements often are accompanied by payment of a fee to the surrogate mother.[331] It has been argued that it is an affront to human dignity and integrity for a woman, in effect, to rent her uterine capacity to another. It has been contended, moreover, that such a practice invites exploitation of disadvantaged women by the more economically powerful. If widespread, the practice could lead to the establishment of a veritable "class" of child-bearing women. A corollary of this argument is that surrogate motherhood degrades the child for whose conception and transfer money is exchanged, by treating him or her like a commodity. In this argument, the promises of the surrogate mother respecting the child are assimilated to an agreement to buy and sell an existing child, which, in some jurisdictions, is either proscribed generally or, as in Ontario, proscribed in relation to adoption.

On a more abstract, philosophical level, it has been contended that, by its very nature, surrogate motherhood embraces an offensive utilitarianism, independent of payment, insofar as it involves the use of one person as a means to the ends of another. That one person may be so used by another, it has been argued, is in and of itself unethical.[332]

Certain arguments relate to the alleged effects of a surrogate motherhood arrangement on the surrogate mother and the child. It has been suggested that the practice should be prohibited because of the physical and psychological risks assumed by the surrogate mother. The physical risks are those associated with pregnancy. The psychological risks arise from surrender of the child following birth. While the former are well known and can be appreciated, the latter are unfamiliar in the absence of accumulated experience and empirical study.

There has also been speculation that there may be a risk to the unborn child in being carried by a mother who intends to surrender the child immediately after birth. Further, it has been contended that the child is at some risk due to the severance of bonds with the surrogate mother. Finally, there have been suggestions that psychological damage may be caused to the child upon learning of the circumstances of his introduction into the family.

Other arguments relate to the possible death of one or both of the social parents prior to the birth of the child and to the possibility that a handicapped child may be born. Yet another matter that has been raised is the difficulty of enforcing such an arrangement in the face of a recalcitrant surrogate mother.

---

[331] See, for example, Queensland Report, *supra*, note 2, at 116-17.

[332] See Warnock Report, *supra*, note 2, para. 8.17, at 46.

In response to the arguments raised against surrogate motherhood, it bears emphasizing that many of the criticisms are based primarily on the fact that such arrangements are operated often on a profit basis. The objections relating to the debasement and exploitation of women and the treatment of children as commodities, while directed generally against the practice of surrogate motherhood, in fact focus exclusively on the profit-making aspects of these arrangements. Were such aspects controlled, these arguments would be undermined considerably.

We find unpersuasive the argument that surrogate motherhood should be proscribed because one person should not serve as a means to an end for another. As an abstract principle, the proposition appears attractive as a ringing rejection of a utilitarian approach to humanity. However, as an absolute precept for governing conduct, its impracticability is demonstrated daily. On a very trivial level, we see the principle ignored wherever services are purchased and sold. A more relevant illustration of its inapplicability occurs in the case of an organ donation for a therapeutic purpose by a live donor. While the recipient is "using" another person to realize an "end", we do not find this conduct offensive to fundamental values, even though, in the case of a kidney transplant, the donor may be taking a risk, since the remaining kidney may later fail. Accordingly, we would suggest that the principle that one person should not serve as a means to an end for another is not an absolute one to which deference must be paid, but that each situation must be evaluated independently to assess its ethical propriety.

With regard to the physical risks associated with pregnancy, we observe that, while they certainly do exist, they can be minimized by providing proper medical care. Moreover, the risks can be communicated and need not be assumed by anyone with even a residuum of doubt.

We are more concerned about the arguments respecting the potential psychological dangers to the surrogate mother and the child arising from the transfer of custody after birth. While in no way deprecating these arguments, we wish to indicate that, at this juncture, the effects of surrendering custody on mother and infant are not evident. Particularly speculative, we understand, is the present state of knowledge about the degree of bonding of the infant in the womb. In view of this uncertainty, we are not persuaded that prohibition is warranted.

With respect to the concerns that have been expressed about the possible death of the social parents, the birth of a handicapped child, and enforcement of the agreement, we believe that each can be addressed effectively by legislation.

On the question of the general approach to be taken to surrogate motherhood, the Commission is divided. A majority of the Commission endorses the practice, but recommends that legislation should be enacted to establish a regulatory scheme governing surrogate motherhood arrangements. One Commissioner favours recommending prohibition of surrogate motherhood as being contrary to public policy; he is of the view that regulation would imply state approval of such arrangements.[333]

The conclusion of the majority in respect of surrogate motherhood reflects the position articulated by the Commission concerning the propriety of the artificial conception technologies. It will be recalled that, when considering the propriety of these technologies, we addressed the argument that the new reproductive technologies ought to be prohibited because they are "unnatural". For many, this objection is fundamental to surrogate motherhood as well, in the sense that no amount of regulation could cure what for them is its inherent ethical unacceptability. However, the labelling of surrogate motherhood as "unnatural" unfortunately has the effect, whether intended or not, of casting the burden of justifying the practice upon its proponents, without advancing compelling arguments in favour of prohibition.

The majority of the Commission is of the view that, in principle, prohibitory action is warranted only where there is an extremely powerful justification; the onus should be on those who would advocate such action, not on those whose conduct is to be the subject of legislative or other interference.

In the context of surrogate motherhood, as in the earlier context of artificial conception generally, the majority of the Commission is of the view that recourse to medical means of alleviating the effects of infertility or genetic impairment cannot conscionably be forbidden. It does not see the endorsement of this practice as foreshadowing the dissolution of the family, nor does it accept that only harm can come to the child or children involved. Indeed, by assisting an otherwise childless couple, surrogate motherhood may be the sole means of affirming the centrality of family life. While, then, the majority acknowledges and respects the views of those who espouse prohibition, and believes that such opposition may properly animate individual moral values and decisions, it rejects the notion that prohibitory action in relation to surrogate motherhood is warranted in the public interest.

A further factor, which weighed heavily, was our belief that, given the relative accessibility of artificial insemination, prohibition would result in recourse to clandestine private arrangements that would realize the worst fears of those who oppose this practice. Dangers of exploitation of the weak by the powerful, pregnancies contracted by the irresponsible, and the introduction of infants into inappropriate, even dangerous, circumstances, would seem to be accentuated if the practice were driven underground. At greatest risk would be the child whose place in society would be uncertain. Indeed, the child might be in a worse position than under existing law, where recourse to the courts may be made to determine parentage and custody, the latter according to the best interests of the child.

Accordingly, we have rejected prohibition in favour of a form of regulation, in the belief that the latter best would protect the interests of all concerned, particularly the child who is to be conceived and transferred.[334] It is of importance to note that the Commission's multidisciplinary Advisory Board, which included experts in the fields of child psychiatry, reproductive medicine, social work and law, also took the view that concerns about the well-being of the affected persons would best be met by regulation.

---

[333] Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from the recommendation: see Vice Chairman's Dissent, at page 287 of this Report.

We realize that our position in favour of legislation regulating the practice of surrogate motherhood will be controversial. Those who find the practice abhorrent no doubt will find our reasoning unconvincing. In the final analysis, the question becomes one of fundamental values, which cannot be resolved conclusively to the satisfaction of everyone; the differences merely can be acknowledged.

Having concluded that regulation of surrogate motherhood arrangements is the preferred course, we shall now consider the choice of a regulatory model.

(d) CHOICE OF A REGULATORY SCHEME

In deciding on a basic scheme to regulate surrogate motherhood arrangements, we find that there are two basic approaches that might be adopted. One is suggested by the existing law, under which the court may be involved *ex post facto*. A second appears in the regulation of adoption under the *Child Welfare Act*, which involves prior judicial screening.[335]

From our earlier discussion,[336] it should be apparent that we regard the present law as inadequate to meet the problems raised by surrogate motherhood. That there may be a circuitous avenue available for regularizing the relationship between the child and the intended social parents does not provide the requisite protection for the persons affected, nor the certainty of status and identity for the child who has been conceived. As we have indicated, the efficacy of this procedure depends on the cooperation of the surrogate mother, which is not necessarily assured. Furthermore, the procedure depends on proof of the paternity of the social father. Finally, and most importantly, judicial involvement after the fact comes at a stage when it simply may be too late to protect all concerned.

It is our view that, given the nature of surrogate motherhood arrangements, regulation should take the form of intervention before any aspect of the agreement is implemented and, in particular, before artificial conception technology is employed to achieve a pregnancy. We believe that mandatory minimum standards to which these arrangements must conform should be established unambiguously by statute. Each prospective surrogate motherhood arrangement should be scrutinized to ascertain whether it complies with the enunciated standards. In our opinion, the institutions best suited to undertake this crucial supervisory responsibility are the courts concerned exclusively with family law issues, that is, the Provincial Court (Family Division) and the Unified Family Court.

---

[334] We observe that our position reflects the views of public and voluntary social welfare agencies in the United States, surveyed by the Child Welfare League of America in May, 1983. While many agencies were apprehensive of surrogate motherhood agreements, 66% favoured regulation, 10% favoured no legislation, and 24% favoured prohibition.

[335] See *supra*, ch. 4, sec. 3(b).

[336] See *supra*, this ch., sec. 5(a).

Accordingly, we recommend that, before an artificial conception procedure may be employed in furtherance of a surrogate motherhood arrangement, the approval of the Provincial Court (Family Division) or the Unified Family Court, as the case may be, should be obtained in accordance with the proposals that we shall make in the balance of this chapter. In order for a court to evaluate the acceptability of a surrogate motherhood arrangement in accordance with legislative standards, we recommend that the terms of the agreement should be in writing. The court should be required to approve the terms and to ensure that they adequately protect the child and the parties and are not inequitable or unconscionable.

Our preference for prior judicial screening raises a question concerning the form that judicial intervention should take. The most obvious model of prior judicial intervention is found in the adoption provisions under the *Child Welfare Act*.[337] This model is useful, insofar as it involves the court in determining the status of the child on the basis of the best interests of that particular child. However, while we regard adoption as an informative precedent for a scheme of prior intervention, we believe that neither of the two forms of adoption set out in the *Child Welfare Act* is suitable for replication in the context of surrogate motherhood.

It will be recalled that adoption by step-parents and close relatives[338] is subject to a lesser degree of scrutiny than adoption by other persons, to whom we referred earlier as "strangers". In the case of the latter, the prospective adoptive parents are subjected to a homestudy, in which they are closely evaluated by a social worker prior to placement of the child in their home. Before the court issues an order finalizing the adoption, the child must be in the home for a probationary period of at least six months, during which the mutual adjustment of child and adoptive parents is monitored. In the case of step-parent or close relative adoption, placement of the child does not require prior approval. Nor is there a requirement that a homestudy be conducted of the step-parent or close relative wishing to adopt. On the hearing of the application, a report on the adjustment of the child in the home is not mandatory, although the court has a power to direct that such a report be prepared and submitted.

We believe that the rigorous intervention in the case of adoption by strangers is an inappropriate regulatory model for surrogate motherhood arrangements. In most cases, we anticipate that such arrangements will involve artificial insemination of the surrogate mother by the semen of the male partner of the couple wishing to raise the child. Since he is the natural father of the child, we do not consider it appropriate that he be treated as a stranger, and that he and his partner be subjected to the invasive scrutiny of a homestudy. While there may be occasions where artificial conception technology is employed to achieve a pregnancy where the male is not the natural father, we consider that such cases will be relatively few in number and, therefore, should not affect the view espoused above.

---

[337] See, now, the new *Child and Family Services Act, 1984*, *supra*, note 41, Part VII.

[338] With respect to "family adoption" under the *Child and Family Services Act, 1984*, *ibid.*, see ss. 130(1)(c) and 140(2).

We also believe that the procedure for step-parent or close relative adoption is not appropriate in this context. Notwithstanding that the relationship between the social parents and the child may in form resemble that in a step-parent adoption — the male will usually be the biological father of the child, in which case his wife will be a step-parent — the reasons for less rigorous intervention that apply to step-parent adoption do not apply to surrogate motherhood. In the case of step-parent adoption, the judicial order regularizes an existing relationship between one spouse in a marriage and a natural child of the other spouse, born in an earlier relationship or possibly out of the marriage. An application for an adoption order presents the court with what is in effect a *fait accompli:* if the application were to be refused, the child would remain the legal responsibility of the natural parent and continue to reside with the applicant for adoption. In recognition that little purpose may be served in refusing the application, courts almost invariably approve step-parent adoption applications without exercising their power to require a report on the adjustment of the child in the home.

In the case of adoption by one of the special class of relatives, it would appear that the less rigorous scrutiny may be founded on an assumption that there is a close relationship between the child and the applicant, and that, in many cases, the child is already living with the applicant.

The procedure for step-parent or close relative adoption is, therefore, a procedure intended to respond to an existing set of circumstances, rather than a procedure with a prospective focus, designed to determine whether a particular situation should be allowed to occur. Such a determination, we think, should be assigned to the courts in supervising surrogate motherhood agreements.

At this juncture, we wish to outline the major features of the recommended scheme. Under this scheme, a prospective surrogate mother and the couple who wish to raise the infant must reach a written agreement that, at a minimum, addresses certain matters specified by the legislation. Before the necessary artificial conception procedure may be performed lawfully, the parties to the agreement must submit the agreement to the court and obtain its approval. On the approval hearing, the court will be required to assess the suitability of the parties to participate in the surrogate motherhood arrangement. If the court is satisfied as to their suitability and the conformity of the agreement with specified legislative criteria, it will approve the arrangement. Immediately following the birth of the child, consistent with the agreement, the surrogate mother will be required to surrender custody of the child to the approved parents. The status of the child in its new family will be confirmed by legislation and reflected in its birth registration.

Having outlined the basic regulatory scheme, we shall proceed to discuss its constituent elements. Each aspect of the procedure is a response to a particular concern that has arisen, or that may arise, in connection with surrogate motherhood arrangements. The ensuing discussion will first consider the participants — the prospective parents, the surrogate mother, and the court. We shall discuss the terms that should be required by statute to be incorporated in each agreement, with particular emphasis being given to the promise of the surrogate mother to surrender the child. Specific proposals respecting the child will be made. It bears emphasizing that all the proposals that we shall make, individually and in concert, are directed to protecting the child by ensuring that it is introduced into a healthy, nurturing environment without uncertainty or controversy.

We shall give separate consideration to the possible intervention of intermediate agencies in the arrangement of surrogate motherhood agreements. Finally, we shall discuss briefly certain miscellaneous issues and our proposed response to efforts to evade the regulatory scheme.

(e) THE PROPOSED REGULATORY SCHEME

(i) The Prospective Parents

As indicated, our recommendation in favour of regulation is based on our view that this approach would best serve the interests of all persons affected by surrogate motherhood arrangements. With respect to the prospective parents, there may be certain tensions associated with recourse to surrogate motherhood, tensions with which some individuals or couples will be unable to cope effectively. In addition, the suitability of the prospective parents will be crucial to the well-being of the child. Both these concerns can be met, we believe, if the prospective parents are evaluated prior to their involvement in surrogate motherhood arrangements.

Accordingly, we recommend that, on the hearing of the application for approval of a surrogate motherhood arrangement, the court should be required to assess the suitability of prospective parents for participation in such an arrangement.

The questions of who should be approved as parents under a surrogate motherhood arrangement and what standards should be applied in assessing applicants raise philosophical and practical issues similar to those that we considered earlier in our discussion of eligibility for participation in an artificial conception programme.[339] We turn now to consider these questions.

a. Medical Indications for Approval

Earlier we noted certain medical reasons why a couple may seek the assistance of a surrogate mother. A woman may lack a uterus or suffer from a serious heart condition that would render a pregnancy a risk to her life or health. However, there may be other reasons for recourse to this alternative. In the literature, it has been suggested that surrogate mothers might be sought for reasons of convenience. The usual example refers to women who prefer not to disrupt other endeavours, such as a career, or who wish to avoid the physical effects of pregnancy.

---

[339] See *supra*, this ch., sec. 3(b).

While we are not aware of any documented instance of surrogate motherhood being used for a nonmedical reason, the fact that artificial conception technology may be so employed obliges us to consider whether this is appropriate.

We observe that all members of the Warnock Committee, including those who dissented with respect to the prohibition of surrogate motherhood, were unanimous in their denunciation of surrogate motherhood for reasons of convenience. The Report stated that "surrogacy for convenience alone, that is, where a woman is physically capable of bearing a child but does not wish to undergo a pregnancy, is totally ethically unacceptable".[340] Other bodies that have expressed reservations about the practice of surrogate motherhood have indicated that their concerns are accentuated by the possibility of its use for reasons of convenience.[341]

We share these views concerning the use of surrogate motherhood for nonmedical reasons. Our sole purpose in allowing individuals to pursue surrogate motherhood arrangements under strict control is to respond to infertility, not to afford individuals the opportunity to satisfy their lifestyle preferences. Accordingly, it is our recommendation that, before the court approves a surrogate motherhood arrangement, the prospective parents should be required to satisfy the court that there is a medical need not amenable to alleviation by other available means, including the employment of the artificial conception technologies. In other words, surrogate motherhood should be a solution of last resort.

b. Assessing the Parents:
Marital Status and Other Factors

Under our proposed regulatory scheme, the court would be asked to approve prospective parents for participation in a surrogate motherhood arrangement. From conferral of this responsibility a question naturally arises as to how the court is to assess their suitability. It will be recalled that, in the context of the artificial conception technologies, we left the determination of suitability to medical practitioners who, we recommended, were to be guided by regulations made under the *Health Disciplines Act*.[342] These regulations would limit the availability of artificial conception technology to stable single women and to stable men and women in a stable marital or nonmarital relationship.[343]

In formulating a test for assessing the suitability of prospective parents for participation in a surrogate motherhood arrangement, we do not consider that the rigorous scrutiny undertaken in the course of stranger adoption is appropriate.

---

[340] Warnock Report, *supra*, note 2, para. 8.17, at 46.

[341] See, for example, ACOG Policy Statement, *supra*, note 309.

[342] *Supra*, note 25.

[343] See *supra*, this ch., sec. 3(b)(i).

We wish to emphasize that we do not question the propriety of the legislative "best interests" standard that guides the court in deciding whether to make an adoption order.[344] What we do consider inappropriate in the context of surrogate motherhood is the extremely strict criteria that are employed by children's aid societies in assessing the suitability of prospective adoptive parents prior to the placement of newborn children. This rigour reflects the dearth of infants available for adoption, which allows, and indeed perhaps even requires, agencies to be extremely selective. In our view, these criteria simply reflect the practical circumstances in which the "best interests" test is applied, rather than a substantive definition of that standard.

In considering the assessment of the prospective parents, we first addressed the issue whether eligibility to apply to the court for approval should be restricted on an *a priori* basis. On this issue, we are divided. A majority of the Commission believes that the availability of surrogate motherhood should not be restricted on an *a priori* basis, but should depend on an assessment of the suitability of applicants according to legislated standards. A minority takes the view that only married couples in stable unions should be allowed to apply to the court for approval to participate in a surrogate motherhood arrangement.[345]

Notwithstanding this difference of views, all members of the Commission agree that legislation should enunciate a substantive test that should be applied by the court in assessing the suitability of prospective parents. Further, we agree that, as the basic test, the court should be required to be satisfied that the intended child will be provided with an adequate upbringing and that, in making this determination, the court should be required to consider certain guidelines. With respect to such guidelines, the Commission is divided. The members of the Commission who oppose a restriction on the availability of surrogate motherhood on an *a priori* basis recommend that the court should be required to consider all relevant factors, including the marital status of the applicants, the stability of their unions, and their individual stability. The members of the Commission who favour restricting the availability of surrogate motherhood to married couples in stable unions would not, of course, include the marital status of the applicants and the stability of their unions as mere factors to be considered. However, leaving aside these two matters, they would propose that the court be required to consider all relevant factors, including the stability of the applicants.

Accordingly, a majority of the Commission recommends that the availability of surrogate motherhood should not be restricted on an *a priori* basis, but should depend on an assessment of the suitability of the prospective parents according to legislated standards. The court should be required to be satisfied that the intended child will be provided with an adequate upbringing, and, in making this determination, the court should be required to consider all relevant factors, including the marital status of the applicants, the stability of their unions, and their individual stability.

---

[344] See *Child Welfare Act*, *supra*, note 41, s. 76(b), and the new *Child and Family Services Act, 1984*, *supra*, note 41, s. 140(1) and (2). For the considerations that may bear upon a determination of the best interests in the context of adoption of a child under the latter Act, see *ibid*, s. 130(2).

[345] Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from the recommendation in favour of regulating surrogate motherhood arrangements: see Vice Chairman's Dissent, at page 287 of this Report. However, if such a procedure were adopted in Ontario, Dr. Leal would require that the prospective parents be married couples in stable unions.

While, for the most part, the proposed standard is self-explanatory, we wish to make one comment. By recommending that the court be satisfied that the child will be given an "adequate" upbringing, we intend to eschew the rigorous standards that are employed by children's aid societies in evaluating couples for adoption, standards that, as we have said, reflect the dearth of infants available for adoption.

c. *Use of Gamete Donors*

For various reasons, it may be necessary for the social parents to rely on gamete donation in the context of a surrogate motherhood arrangement. For example, where the husband may transmit a harmful genetic condition, donor semen must be used if a surrogate mother is to become pregnant. Alternatively, where the wife does not have a uterus, and the surrogate mother has tubal or ovarian problems, an ovum would have to be donated.

Where prospective parents seek the assistance of gamete donors, we believe that the donors should acquire no standing in the approval proceedings. On grounds of both principle and logic, they should be subject to the recommendations that we have proposed to govern gamete donation for the purpose of artificial conception.[346] Accordingly, we recommend that, where a donated gamete is to be used in a surrogate motherhood arrangement from a donor who is neither the prospective surrogate mother nor a prospective social parent of the intended child, the treatment of the donor should be governed by the previously recommended provisions concerning gamete donors.

(ii) The Surrogate Mother

Judicial approval of prospective surrogate mothers prior to performance of the artificial conception procedure is, in our view, absolutely crucial to the protection of the unborn child, the prospective parents, and indeed, the surrogate mother herself.

As far as the unborn child is concerned, whether the surrogate mother is to gestate an ovum supplied by another or her own fertilized ovum, her physical and mental state, both before and during pregnancy, will affect the health of the fetus. Where she is the genetic mother, her greater contribution to the child's development will increase the importance of assuring her health and, in particular, the absence of any deleterious genetically transmissible condition.

From the perspective of the social parents, the physical and mental state of the surrogate mother is important not only because it bears upon the health of the child whom they will raise, but because it affects whether she will be conscientious in adhering to her agreement. A prospective surrogate mother should appreciate fully the nature of the obligations she has undertaken so that her cooperation will be assured when it is time to transfer custody of the infant.

---

[346] See *supra*, this ch., sec. 3(c).

Judicial approval of the surrogate mother may also be of importance to the woman herself. Certain physical and psychological risks would appear to be associated with participating as a surrogate mother. The physical risks are those usually attendant upon pregnancy, which may involve various complications and may even have a long-term effect on a woman's health. While there have been no studies of psychological risks associated with the transfer of the newborn infant, this possibility must be acknowledged. Because of these risks, it would be advisable to exclude from participation in surrogate motherhood arrangements women who are demonstrably unsuited to the role, either because they are patently maladjusted or unstable, or because they clearly do not appreciate the nature of surrogate motherhood.

For these reasons, we recommend that, on the hearing of the application for approval of a surrogate motherhood arrangement, the court should be required to assess the suitability of the prospective surrogate mother.

We turn now to consider first, whether there should be any limits on eligibility to become a surrogate mother and, secondly, the criteria for assessment of prospective surrogate mothers.

a. Eligibility to Act as a Surrogate Mother

It has been suggested that the opportunity to participate as a surrogate mother should be restricted to certain categories of women. It has been argued, for example, that such participation should be limited to women who already have given birth to children, because only they can truly appreciate the risks associated with pregnancy and the implications of surrendering a child upon birth. Alternatively, it has been said that women with children in their care should not be allowed to be surrogate mothers because these children may be traumatized upon surrender of the infant, fearing that they too will be given away. In addition, some commentators have suggested that married women are to be preferred, in the expectation that their husbands will be bulwarks of emotional support; others have taken an opposite view, in the belief that husbands will be potential sources of conflict.

We consider that there is no theoretical or empirical basis upon which to adopt a categorical approach to the eligibility of women to serve as surrogate mothers. This conclusion is, however, subject to a single exception. Under no circumstances whatsoever do we believe that a minor should be permitted to participate in a surrogate motherhood arrangement as a surrogate mother.

Earlier, we recommended that legal minors should be prohibited from acting as ovum donors because of the surgical risks involved and concerns about the genuineness of their consent.[347] In addition, in the case of *in vivo* fertilization and lavage, we were concerned that the ovum donor might become pregnant through the failure of the lavage technique. Similar concerns animate our rejection of minors becoming surrogate mothers. While this view may appear harsh in circumstances where, for example, a mature seventeen year old wishes to assist a close relative, we believe strongly that minors should not be exposed to the risks attendant upon surrogate motherhood.

It should be noted that, in order to prevent minors from applying for approval as surrogate mothers, it will be necessary to enact specific legislation. Pursuant to the regulations made under the *Public Hospitals Act*,[348] persons aged sixteen or over are legally competent to give autonomous consent to medical care;[349] accordingly, a minor could present herself for an artificial conception procedure.

Accordingly, we recommend that there should be no restriction on the eligibility of women to serve as surrogate mothers, so long as they have reached the age of majority at the date of the application for court approval of their participation in a surrogate motherhood arrangement.[350]

b. Assessment of Prospective Surrogate Mothers

Not surprisingly, there is virtually no scholarly writing about the qualities that are desirable in a surrogate mother. Reflecting the lack of experience with this phenomenon, empirical study of applicants and their motivations remains in a nascent stage of development.[351] Notwithstanding the absence of scientific guidance, we have confidence that this assessment can be left to the court, with its attention being directed to certain factors that, in our view, deserve special consideration.

We believe that the court should assess the physical and mental health of the prospective surrogate mother. It is envisaged that evidence respecting her condition, consisting, for example, of reports by doctors, psychologists, or other professionals, will be submitted by counsel for the prospective parents or by her own counsel.[352] Should the information appear incomplete, the court simply could withhold approval of the agreement until further satisfactory evidence is adduced.

---

[347] See *supra*, this ch., sec. 3(c)(ii).

[348] *Supra*, note 165.

[349] R.R.O. 1980, Reg. 865, ss. 50 and 51.

[350] Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from the recommendation in favour of regulating surrogate motherhood arrangements: see Vice Chairman's Dissent, at page 287 of this Report. However, if such a procedure were adopted, Dr. Leal would require that surrogate mothers be married women or widows who have reached the age of majority and have had a child.

[351] See Parker, "Motivation of Surrogate Mothers: Initial Findings" (1983), 140 Am. J. Psychiatry 170.

[352] See *infra*, this ch., sec. 5(e)(iii)b.

Apart from considering the physical and mental state of the woman, the court should consider other matters, which may appear less obviously relevant. We believe that, where prospective surrogate mothers have partners in marital or nonmarital unions, the disposition of these partners to their participation in surrogate motherhood arrangements should be a factor to consider.[353] Where a partner is opposed to her participation, this may augur badly for the woman's state of mind during the pregnancy. This, in turn, may be harmful to the fetus and deleterious to the stability of the surrogate mother's family.

A further factor that should be considered is the effect of the arrangement on the children of the surrogate mother. If there are indications that they might be psychologically harmed by her participation and, in particular, by the planned transfer of custody, a court should not approve her involvement. It would be unconscionable to sacrifice knowingly the emotional stability of an otherwise secure child in the interests of creating another child.

We therefore recommend that, in assessing the suitability of a prospective surrogate mother, the court should consider, among other factors, her physical and mental health, her marital and domestic circumstances, the opinion of her spouse or partner, if any, and the likely effects of her participation in a surrogate motherhood arrangement upon existing children under her care.

(iii) The Court

For reasons discussed earlier,[354] we believe that the court should have the crucial responsibility for assessing the suitability of participants in a surrogate motherhood arrangement. While the role that we have assigned to the court may appear roughly similar to that of the court in the context of adoption, in fact the responsibility would differ substantially. In adoption, whether by a stranger or by a step-parent or close relative, the court gives legal finality to the relationship between the child and his or her new family *after* the child has been placed in the home. Moreover, even in the case of a stranger adoption, the court does not engage in detailed prior scrutiny of the prospective parent; that task is undertaken by social workers acting under the auspices of a children's aid society, a private adoption agency, or a licensed individual. Under our proposed scheme, by contrast, the court is to make the critical assessment before any action is taken lawfully to alter the *status quo*.

Notwithstanding this difference, we envisage that the general configuration of the hearing will be similar to adoption, in the sense that the proceedings will be non-adversarial in character. We anticipate that the parties represented will be the prospective social parents, the prospective surrogate mother and, as we shall explain shortly,[355] possibly a children's aid society. At the hearing, the interests of the surrogate mother will be coincidental with those of the prospective parents. Thus, in the absence of countervailing submissions and evidence, the court generally will be asked to approve an application that is unchallenged.

---

[353] See Parker, *supra*, note 351, and Parker, "Surrogate Motherhood: The Interaction of Litigation, Legislation and Psychiatry" (1982), 5 Int'l J. L. & Psychiatry 341.

[354] See *supra*, this ch., sec. 5(d).

In this section, we shall discuss certain issues relating to the substantive task that we recommend should be assigned to the courts and to the conduct of the hearing in which that responsibility will be discharged.

a. Standard of Proof for the Approval of Agreements

In earlier sections, we discussed the substantive tests that should be used in deciding whether to approve the participation of the parties to a surrogate motherhood arrangement.[356] A question arises whether, in light of the protective policy underlying the establishment of our regulatory scheme, the standard of proof otherwise applicable to civil proceedings is appropriate.

In civil proceedings, the balance of probabilities standard prevails. In other words, in order to succeed a party must persuade the court that his version of the facts or his argument is more likely than not supported by the evidence. This standard is to be contrasted with the stricter criminal burden of proof, which requires the establishment of facts beyond a reasonable doubt.

In the course of our deliberations, we considered the argument that a standard higher than the usual civil standard is warranted in these proceedings in view of their non-adversarial character. According to this argument, a heavier burden of persuasion should be cast on the applicants in order to compensate for the fact that their position is not going to be tested by a party opposed in interest.[357]

We are not persuaded, however, that a different standard of proof should apply in this context. We observe that family law matters in Ontario are subject to the traditional balance of probabilities standard. Moreover, this standard governs proceedings that are non-adversarial, including those where the welfare of a child is at stake. For example, in adoption proceedings, which are usually uncontested, the applicant is not required to satisfy a higher burden of proof. Hence, the special regard for the interests of children, which so pervades family law in Ontario, has not led to the modification of the ordinary standard of proof.

---

[355] See *infra*, this ch., sec. 5(e)(iii)d.

[356] See *supra*, this ch., secs. 5(e)(i) and (ii).

[357] A standard somewhat less strict than the criminal standard, but nevertheless demanding, has been approved by the United States Supreme Court in domestic proceedings. This standard is directed to protecting children from risk, but also respects the reasonable expectations of the parents not to be denied custody of their children. It requires that proof be established on a standard of clear and convincing evidence: see *Santosky v. Kramer*, 455 U.S. 745 (1982). In this case, the standard had to be satisfied by the evidence of the party seeking to have a child removed from parental custody.

Against this background, we believe that it is neither necessary nor advisable for the Commission to make a recommendation respecting the standard of proof that should apply on the hearing of applications to approve surrogate motherhood arrangements. This issue should be left to the courts charged with the responsibility of determining the application. Presumably, this would mean reliance on the ordinary civil burden of proof unless, and until, it is decided that it is inappropriate.

b. The Prospective Surrogate Mother as a Co-Applicant

We have already discussed the importance of approving the participation of the prospective surrogate mother and the test for assessing her suitability.[358] Ancillary procedural issues relate to whether the surrogate mother should be a co-applicant in the proceeding, along with the prospective parents, and whether she should be required to attend the proceedings.

With respect to the first issue, the status of a surrogate mother as a co-applicant is necessary if the court order is to be binding on her. With respect to the second issue, the attendance of the prospective surrogate mother at the hearing would appear desirable as a matter of principle. It would allow the court better to consider her suitability and to ascertain her understanding of her contractual commitment. In particular, the court could attempt to determine whether she has received independent legal advice and counselling by professionals unconnected to the prospective social parents.

Requiring the attendance of the prospective surrogate mother at the hearing of the application, however, might involve her meeting the prospective social parents. Where both parties prefer that they should be unknown to each other, such a requirement would defeat their intentions. We see no reason to recommend a measure that might frustrate the legitimate wishes of the parties.

From our survey of the relevant literature, it is apparent that persons in the United States involved in these agreements choose various arrangements, depending on their individual and mutual preferences. While some agreements may involve disclosure of identity and personal meetings between the parties, others are negotiated and implemented in circumstances of mutual anonymity.

Based on the available literature, there is at present no basis for proposing normative guidelines concerning the nature of the relationship of the parties to a surrogate motherhood arrangement. We prefer to remain silent on this matter, allowing the parties and their lawyers to make their own determinations of what best suits their needs. Thus, while we are of the view that prospective surrogate mothers should be co-applicants in the proceedings, we do not wish to compel their attendance at the hearing as a rule. Should the court wish to receive testimony from the surrogate mother or to observe her in person, it could request her attendance and provide that the prospective social parents be absent.

---

[358] See *supra*, this ch. sec. 5(e)(ii).

We do wish, however, to emphasize the necessity of the prospective surrogate mother receiving separate legal representation at the hearing. Separate representation will accord a measure of protection to the surrogate mother and lessen the danger of exploitation, which justifiably has concerned those critical of unregulated surrogate motherhood arrangements.

Accordingly, we recommend that the surrogate mother should be a co-applicant in the proceedings, but that she should not be required to be in attendance at the hearing of the application in every case. We recommend also that the surrogate mother should receive separate legal representation.

c. Blood, Tissue and Other Testing of Parentage

Upon the birth of a child following judicial approval of a surrogate motherhood agreement, a question may be raised concerning whether the child is in fact the product of that arrangement. The biological paternity of the child may be contested by a prospective social father if the child is found to be affected by a genetic defect, or if his wife wants assurance that it is his child whom she is to be legally responsible for rearing. Similarly, a surrogate mother, perhaps seeking to resist surrender of the child, may deny the paternity of the prospective social father.

This issue would appear to be of special concern where a prospective surrogate mother is cohabiting with a husband or male partner. In such a case, the prospective parents will want assurance that the child has developed from the sperm of the social father or, where donated semen is used, from the sperm of the carefully selected, screened, and matched donor, and not from that of the surrogate mother's husband or partner. Accordingly, the surrogate mother will usually be asked to give undertakings that sexual relations will be avoided at the time of insemination, in order to ensure that the sperm then used will account for any pregnancy that ensues.

The issue could also arise, although much less frequently of course, in the context of a maternity dispute, where, for example, a donated ovum is used. Indeed, the ovum might be donated by the prospective social mother.

Disputes respecting the parentage of a child, which will be accompanied inevitably by disagreements over custody, obviously are detrimental to all concerned, especially the child, whose parentage and future will be cast in doubt.

Scientific means are available to avoid unnecessary disputes about parentage. Blood tests, tissue tests and similar methods of genetic diagnosis may establish the child's biological parents with reliable accuracy.[359] Acquisition of blood or tissues for such a diagnosis from the surrogate mother and the prospective social parents should cause no special problem, since the physicians involved would be expected to establish their respective blood groups and similar characteristics. Where anonymous donor gametes are used, the gametes may be required to carry documented information of the donor's blood group and similar biological status. Conscientious screening of donors should make the data readily available.

---

[359] For a discussion of the efficacy of Human Leucocyte Antigen (H.L.A.) blood tissue testing, see Shaw and Kass, "Illegitimacy, Child Support and Paternity Testing" (1975), 13 Houston L. Rev. 41, and Lee, "Current Status of Paternity Testing" (1975), 9 Family L.Q. 615.

A disadvantage of testing is that it may require a newborn child to suffer blood-drawing or a biopsy. The risk and discomfort of these procedures are normally considered acceptable.[360] Moreover, it should be emphasized that the *Children's Law Reform Act*[361] permits blood testing of infants.

We believe that the available technology should be used to avoid, or at least reduce, unnecessary uncertainty respecting the parentage of a child, and to limit the opportunity of a surrogate mother to refuse to surrender the child on the ground that it is not the child of the approved arrangement. As the testing of children and adults to determine parentage after birth is permitted now under the *Children's Law Reform Act*, there is no need for specific legislation to address this matter. In order to require that the blood groups and other relevant biological characteristics of the adults involved — the surrogate mother, her husband or male partner, if any, and the persons who produced the gametes involved — are reliably and accessibly recorded prior to birth, legislation would have to be enacted.[362]

We believe that the responsibility for ensuring that this information is compiled should rest with the court as part of its supervisory function. Accordingly, we recommend that, in order to minimize uncertainty concerning a child's parentage upon birth, prior to the approval of a surrogate motherhood arrangement the court should require to be placed before it information relating to blood type and other relevant biological characteristics of the surrogate mother, her husband or partner, if any, and the persons who produced the gametes involved.

---

[360] See *S. v. McC; W. v. W.*, [1972] A.C. 24 (H.L.).

[361] *Supra*, note 122, s. 10.

[362] Section 10(1) of the *Children's Law Reform Act, supra*, note 122, provides that, "[u]pon the application of a party in a civil proceeding in which the court is called upon to determine the parentage of a child, the court may give the party leave to obtain blood tests of such persons as are named in the order granting leave and to submit the results in evidence". This provision would allow blood testing to determine parentage only after the birth of a child. Our concern is to ensure that information pertaining to parentage is available prior to the birth of a child pursuant to a surrogate motherhood arrangement in order to avoid a parentage dispute or, where a dispute nonetheless occurs, to expedite its resolution.

d. Participation of the Children's Aid Society

While we have recommended that the important responsibility for vetting prospective parties be assigned to the court, we believe that children's aid societies may play a useful role in the process. We have indicated already that the hearing of the application will be non-adversarial in nature, since the interests of the prospective parents and the surrogate mother will coincide. Neither party will have an interest in adducing evidence tending to demonstrate the unsuitability of the other. We believe, therefore, that there is good reason to provide for the involvement of a reliable source of information independent of the parties, whose participation can avoid the approval of the patently unsuitable.

In our view, children's aid societies are well suited to undertake this responsibility. We should emphasize, however, that we do not favour involvement similar to that in the context of stranger adoption, where a homestudy of the prospective parents is required in every case. Rather, we believe that children's aid societies should have standing to intervene in the proceedings only where their records disclose information demonstrating the unsuitability of either the surrogate mother or the prospective parents for participation in the proposed arrangement. Where the information available does not disclose any reason to be concerned about the parties, participation in the proceedings would not be necessary.

We realize that the introduction of this additional precaution may cause some discomfort to the parties, whose confidentiality will be compromised through the unavoidable disclosure of their identities to a children's aid society.[363] One response to concerns about the disclosure of parties' planned participation in a surrogate motherhood arrangement is that the staff of children's aid societies do observe proper confidentiality. In our view, however, the decisive consideration is that the applicants are seeking judicial approval of an arrangement that will culminate in the birth of a child, whose best interests are the overriding factor. To that factor, all others are subordinate, including concerns about possible embarrassment or vulnerability attendant upon revelation of admittedly sensitive information.

Accordingly, we recommend that notice of an application to the court for approval of a surrogate motherhood arrangement should be served upon the appropriate children's aid society, and that the society should have standing to attend at the hearing of the application. However, a children's aid society should intervene only where its records disclose information demonstrating the unsuitability of either the surrogate mother or the prospective social parents for participation in the surrogate motherhood arrangement.

---

[363] Where, for example, a party is a member of the Roman Catholic community of Toronto, Hamilton or Windsor, the local Catholic Children's Aid Society will become involved. In view of the position of the Roman Catholic Church in relation to the artificial conception technologies and surrogate motherhood, this discomfort may be significant.

e. Confidentiality of the Proceedings and the Court Record

In the previous section, we alluded briefly to our expectation that the participants in a surrogate motherhood arrangement would wish to preserve confidentiality. The reasons for respecting the privacy of the parties and the unborn child should be so patent as not to warrant explanation. Suffice it to say simply that the sensitivity and intimacy that we associate with human reproduction is accentuated significantly in the circumstances of artificial conception.

We observe that, in the context of adoption, the relevant legislation provides for certain measures that are intended to protect the privacy of all persons affected by the order for adoption. The *Child Welfare Act* requires that an application for adoption be heard and determined *in camera.*[364] Further, it provides that the documents used in the application for an adoption order must be sealed and filed in the offices of the court and cannot be opened for inspection, except upon an order of the court or the written direction of the Director of Child Welfare.[365] The regulations also require that the court records be maintained in a manner designed to ensure anonymity.[366]

While somewhat less rigorous standards of confidentiality apply to other sensitive proceedings under the *Child Welfare Act*,[367] we believe that the adoption analogy is the appropriate one in dealing with this issue. However, not all aspects of the legislation providing for confidentiality in adoption are transferable to this context. For example, since the Director of Child Welfare is not involved in the proposed scheme, he or she should have no power to direct the opening of a court file. Access to court files should be determined by the court alone. Also irrelevant are the regulations providing that the surname of the child is not to be recorded on documents, as the child does not exist at the time of the hearing. These differences are minor in character.

---

[364] *Child Welfare Act*, *supra*, note 41, s. 71(2). See, also, the *Child and Family Services Act, 1984*, *supra*, note 41, s. 145(1).

[365] *Child Welfare Act*, *supra*, note 41, s. 80. The rule respecting the secrecy of these documents is subject to an exception where information is disclosed through the operation of the voluntary disclosure registry: see *Child Welfare Act*, *supra*, note 41, s. 81. The information, however, may be provided only to an adopted child eighteen or older or to a person who was a parent of the child at the time of the child's birth. Of course, the secrecy of the court records in relation to the world at large would remain unaffected. See the *Child and Family Services Act, 1984*, *supra*, note 41, ss. 145(2) and 157. Section 145(2) provides that, subject to exceptions in favour of the court and its authorized employees, the parties to an application for an adoption order and their solicitors and agents, and a Director and a local director, "[n]o person shall have access to the court file concerning an application for an adoption order". Section 157(1) provides for the confidentiality of information relating to an adoption kept by the Ministry of Community and Social Services, by a children's aid society or licensee, or in the voluntary disclosure register. Certain exceptions permit inspection or disclosure of information: *ibid.*, s. 157(2).

[366] Rule 61 of the Rules of the Provincial Court (Family Division), R.R.O. 1980, Reg. 810, provides that, in adoption proceedings, the child may be identified in any document by his given names in full followed by the first letter of his surname and his birth registration number, and the applicant may be identified in any document, other than the adoption order, by the first letter of his surname.

[367] Proceedings for the care and protection of children, which are held under Part II of the *Child Welfare Act*, are to be held *in camera*, unless the judicial officer holding the hearing, having regard to the wishes and interests of the parties and whether the presence of others would be injurious to the emotional health of any child present at the hearing, directs otherwise. While the judicial officer has power to allow representatives of the press, radio or television media to attend the hearing, it is forbidden to publish or make public any information that has the effect of identifying the affected parties: see *Child*

Accordingly, we recommend that the anonymity of the prospective social parents and surrogate mother and the confidentiality of court records pertaining to the surrogate motherhood proceedings should be preserved. In particular, we recommend that the application should be heard and determined *in camera*, the court records should be sealed, and access to the records should be granted only upon judicial approval for good reason.

(iv) Terms of the Agreement

In this section, we turn to discuss whether our legislative scheme should require that specific matters be addressed in every surrogate motherhood agreement. In the course of reviewing the literature, it soon became evident that certain difficult issues were seen as more important, and capable of having a substantial impact on the persons affected. This led to the question whether these issues should be determined by legislation or whether the court, in approving the agreement, should be required to ensure that they have been confronted and resolved satisfactorily by the parties. As will be apparent from the following discussion, we are of the view that certain issues are so important that they should be addressed by legislation, rather than being left to be resolved by the parties.

In the ensuing discussion, we shall consider four of the most contentious issues — the surrender of the child, the question of payment to the surrogate mother, the possibility of a handicapped child, and the possibility of an abortion by the surrogate mother. We then shall review briefly a list of certain issues that, we believe, the parties to a surrogate motherhood agreement should be required to consider and resolve.

a. Surrender of the Child

Perhaps the most difficult issue that we have addressed in designing an appropriate regulatory scheme is whether, upon birth of the child, the surrogate mother should be under a legal compulsion to surrender the child in accordance with her promise to do so under the surrogate motherhood agreement. In its most stark incarnation, this question reduces to whether, in the face of a refusal by the woman to transfer custody of the newborn infant, a court should be obliged to issue an order to surrender the infant, which could be enforced against her will by seizure of the child.

Welfare Act, *supra*, note 41, s. 57. See, also, the *Child and Family Services Act, 1984*, *supra*, note 41, s. 41.

Without elaborate discussion, it should be obvious that this is one of the most emotionally charged issues involved in surrogate motherhood. That a recalcitrant surrogate mother might be compelled through judicial process to surrender her newborn infant would seem to strike at the very heart of our shared values. For some, this possibility confirms the "unnaturalness" of this reproductive alternative.

We are acutely aware of the necessity of resolving this difficult and controversial issue if the parties to these arrangements, and through them the affected children, are to avoid uncertainty and conflict upon the birth of the child. In striving to arrive at the appropriate solution, we sought guidance in two distinct areas of the law.

First, we turned to contract law and, in particular, the law respecting specific performance. While we have yet to use this term in discussing the issue, the question can be cast in terms of whether the promise of the surrogate mother ought to be specifically enforceable. Although it may appear inappropriate to consider a problem respecting children by reference to contract law, it is useful to do so for analytical purposes.

Speaking generally, specific enforcement of a contract is a remedy available only where monetary compensation is inadequate.[368] For example, a strong argument can be made for specific performance if the contract concerns something that is unique, making it extremely difficult to assess the loss for which monetary compensation otherwise would be given. It also has been established that contracts for personal services are not specifically enforceable, in part because the courts cannot supervise the quality of the service to be rendered.

Applying these principles to a surrogate motherhood agreement, one might well argue that specific performance would be an appropriate remedy in the face of a refusal to surrender the child. Certainly the subject matter of the agreement is unique, and monetary compensation would not replace the loss to the social parents. And, while the entire surrogate motherhood agreement might be regarded as a contract for personal services, the enforcement of which would require judicial supervision — particularly in relation to a promise by the surrogate mother to maintain her health during pregnancy — the promise to transfer the child involves a discrete act that would not necessitate supervision.

While contractual principles may be applied for purposes of analysis, it bears emphasizing that, under the present law, these principles clearly are regarded as inappropriate for resolving disputes concerning the future of children. In an analogous context, the *Family Law Reform Act*[369] provides that "[i]n the determination of any matter respecting the support, education, moral training or custody of or access to a child, the court may disregard any provision of a domestic contract pertaining thereto where, in the opinion of the court, to do so is in the best interests of the child". This provision expressly requires the court to consider a principle — the best interests of the child — that is separate from, and superior to, the intentions evinced in the agreement. In deferring to this principle, the court is undertaking an inquiry very different from that undertaken in dealing with a commercial transaction.

---

[368] See, generally, Sharpe, *Injunctions and Specific Performance* (1983), and Waddams, *The Law of Contracts* (2d ed., 1984), at 507-27.

[369] *Supra*, note 127, s. 55(1).

For example, in a custody dispute, where custody is awarded to the parent who has been given custody under a separation agreement, the court is not truly enforcing the agreement. The agreement, along with various other factors, may be relevant to the court's view of the best interests of the child, but the contractual resolution of custody in no way circumscribes judicial discretion respecting this matter.

The other relevant area of the law that we have considered concerns adoption. Under the *Child Welfare Act*,[370] an adoption order can be made only with the written consent of both parents or the persons having lawful custody and control of the child,[371] except where the court has dispensed with this requirement.[372] Consent, however, cannot be given until after the child is seven days old.[373] Furthermore, any person who has given his or her consent can withdraw it as of right within twenty-one days after it has been given.[374] These measures recognize the importance and potentially traumatic nature of the decision to consent to adoption, and appear intended to ensure that the consent is in fact genuine and continuing. This is most evident in the limitation respecting consent to the adoption of newborn infants, which seeks to protect women in the particularly emotionally vulnerable period shortly after childbirth.

These two areas of the law suggest the only alternative resolutions to the question of surrender. Either the regulatory scheme should provide that the surrogate mother must honour her promise and surrender the child after birth, irrespective of any attitudinal change on her part in the intervening period, or the surrogate mother should be given a right, in effect, to rescind the agreement unilaterally within a period after birth. In the first case, the risk of disappointment and trauma rests on the surrogate mother, while, in the second, it is placed on the social parents.

The crucial question, however, is not where the risk of disappointment should lie, but which resolution will serve the best interests of the child. Unfortunately, the available scientific literature would appear to indicate no clear answer to this question. However, the Advisory Board that assisted the Commission, which included a child psychiatrist and a social worker, favoured requiring immediate surrender of the child to the approved social parents. It was thought that immediate surrender would serve to prevent bonding with the surrogate mother and to facilitate bonding with the person — the social mother — who, in the vast majority of cases, would be the ultimate recipient of the child and who, therefore, would be the primary influence in its life during the neonatal period and infancy.

---

[370] *Supra*, note 41.

[371] *Ibid*., s. 69(2). See the *Child and Family Services Act, 1984*, *supra*, note 41, s. 131(2).

[372] *Child Welfare Act*, *supra*, note 41, s. 69(7). See the *Child and Family Services Act, 1984*, *supra*, note 41, s. 132.

[373] *Child Welfare Act*, *supra*, note 41, s. 69(2). See the *Child and Family Services Act, 1984*, *supra*, note 41, s. 131(3).

[374] *Child Welfare Act*, *supra*, note 41, s. 69(2). See the *Child and Family Services Act, 1984*, *supra*, note 41, s. 131(8).

We have been persuaded that, on balance, the legislation should provide for immediate surrender of the child. Hence, where a surrogate mother refuses to transfer custody, she could be compelled to do so by court order.

It may seem harsh and unfeeling to countenance a situation where, in the face of continuing recalcitrance, officers may be ordered to deliver the infant to the social parents. Yet physical seizure of a child may be effected under the present law in the context of a dispute over custody.[375] Further, there are judicial statements that infants may be taken from their mothers on birth by children's aid society workers where there has been a judicial finding that they are in need of protection.[376]

Accordingly, we recommend that a child born pursuant to an approved surrogate motherhood arrangement should be surrendered immediately upon birth to the social parents. Where a surrogate mother refuses to transfer the child, the court should order that the child be delivered to the social parents. In addition, where the court is satisfied that the surrogate mother intends to refuse to surrender the child upon birth, the court, prior to the birth of the child, should be empowered to make an order for transfer of custody upon birth.

Before leaving this issue, we wish to address a potential problem. In rare cases, in the intervening period between the judicial approval of the agreement and the birth of the child, circumstances may so change as to render undesirable the surrender of custody to the approved parents. While certain reasons why the social parents may become unsuitable to accept the child may be anticipated in the surrogate motherhood agreement, an event may occur that is beyond the reasonable expectations of the parties. Alternatively, information that was not available at the original hearing may come to light, indicating that the social parents are unsuitable. An extreme example might be the conviction of a social parent for commission of a serious offence, such as sexual assault of a child.

---

[375] Section 37(2) of the *Children's Law Reform Act*, *supra*, note 122, which deals with the enforcement of orders for custody and access, provides that, where a court is satisfied that there are reasonable and probable grounds for believing, *inter alia*, that any person is unlawfully withholding a child from a person entitled to custody of or access to the child, it may by order "direct the sheriff or a police force, or both ... to locate, apprehend and deliver the child to the person named in the order". Section 37(4) provides that, if such a direction is given, the "sheriff or police force ... shall do all things reasonably able to be done to locate, apprehend and deliver the child in accordance with the order". Section 37(5) provides further, that, for the purpose of locating and apprehending a child in accordance with an order under s. 37(2), "a sheriff or a member of a police force may enter and search any place where he has reasonable and probable grounds for believing that the child may be with such assistance and such force as are reasonable in the circumstances".

[376] See *Re Children's Aid Society for the District of Kenora and J.L.* (1981), 134 D.L.R. (3d) 249 (Ont. Prov. Ct. (F.D.)) *(obiter dicta)*, cited with approval in *Re Superintendent of Family and Child Service and McDonald* (1982), 37 B.C.L.R. 32, 135 D.L.R. (3d) 330 (S.C.).

While the local children's aid society may intervene upon receiving credible evidence that the child would be in need of protection if delivered to the approved parents, we do not believe that the basis for preventing transfer should be restricted to the circumstances set out in the *Child Welfare Act*. In our view, it would be preferable to allow the surrogate mother, who presumably will have an interest in the welfare of the child, to apply to the court for a review of the approval of the arrangement, where circumstances indicate that the social parents are unsuitable to receive the child. In addition, where, subsequent to the approval of the surrogate motherhood arrangement, the children's aid society receives information indicating that the social parents are unsuitable, the children's aid society should be entitled to apply to the court for a review of the arrangement. On the hearing of the application, the court should be able to rescind the agreement even where the child would not be "a child in need of protection" within the meaning of the *Child Welfare Act*.[377] The custody of the child might be sought by the surrogate mother or by the local children's aid society.

Such a scheme would ensure that the welfare of the child is not sacrificed in the interests of certainty in the rare case where it becomes apparent that the social parents should not receive the child. Whatever dislocation necessarily is entailed in this position is preferable to placing the child at risk.

Accordingly, we recommend that, where there has been a change in circumstances, or where new information has become available, indicating that the approved social parents are unsuitable to receive the child, the surrogate mother or the children's aid society should be permitted to apply, at any time prior to the birth of the child, for a review of the approval of the surrogate motherhood arrangement. The judge should be empowered to rescind the agreement.

b. Payment to the Surrogate Mother

Among the most contentious issues that have arisen in connection with surrogate motherhood is that of payment to the surrogate mother by the persons to whom she will transfer custody of the child. As we have indicated,[378] the matter of payments has been the focus of much of the criticism of surrogate motherhood arrangements. Indeed, most arguments concerning the ethical impropriety of these arrangements are premised on the commercialization of the practice through the payment of a fee to the surrogate mother. Concerns have been expressed about the possibility of exploitation of disadvantaged women by the more affluent, and the dehumanization and debasement of both the surrogate mother and the child attendant upon payment for gestation and relinquishment of custody.[379]

---

[377] *Supra*, note 41, s. 19(1)(b). The definition of "child in need of protection" has been revised in the new *Child and Family Services Act, 1984*, *supra*, note 41, s. 37(2).

[378] See *supra*, this ch., sec. 5(b).

In the course of our deliberations, we have considered four categories of payment. The first relates to the payment of a fee in the way of profit to the surrogate mother for her participation in the arrangement. Whether this fee is characterized as payment for a child, or merely as payment for services,[380] it is this controversial payment that raises the spectre of "baby-buying" and exploitation.

A second category of payment relates to the expenses incurred by the surrogate mother in the course of the arrangement. Our recommendation that the surrogate mother retain independent counsel necessarily will involve legal costs. In addition, a variety of medical and other expenses will be incurred. These will relate, for example, to medical screening and to the production of psychiatric, psychological, and social worker reports for submission to the court in relation to the assessment of the surrogate mother's suitability. Further costs will be incurred during pregnancy, relating to continuing medical supervision and maintenance of a sound diet. Finally, costs will be incurred in delivery and postnatal care, including counselling services for the mother. While the Ontario Health Insurance Plan may be expected to meet many of these costs, not all payments for services agreed between the mother and the social parents may be reimbursed by the Plan, and not all services may be conveniently available through medical practitioners who practice under the Plan or whose bills are limited to Plan fee schedules.

A third category of payment that has been suggested is payment for lost income and lost earning opportunities during the course of the pregnancy and the postpartum recuperative period. A fourth type of payment relates to compensation for pain and suffering, including, perhaps, postpartum grief for loss of the child.

All members of the Commission agree that no payment should be made in relation to a surrogate motherhood arrangement without the approval of the court. However, we are divided on which items of payment should be permitted by the legislation and the degree of discretion to be given the court.

One view is that the issue of payment should be left entirely to the court, without any legislative guidance as to which payments are to be permissible. A second view is that the court should be given a general power to approve payments, and should be expressly instructed that this power may extend, but is not limited, to payments for medical and similar costs, related out-of-pocket expenses, and lost income or earning opportunities. A third view is that the power of the court to approve payment should be confined to specified items only; however, there is a division respecting the items for which payment may be made. One Commissioner favours allowing the court to approve payments for medical and similar costs, related out-of-pocket expenses, and lost income or earning opportunities; the other[381] would restrict the list of items to medical and similar costs and related out-of-pocket expenses.

---

[379] See discussion, *supra*, this ch., sec. 5(c).

[380] See, for example, Note, "Surrogate Mothers: The Legal Issues" (1981), 7 Am. J. L. & Med. 323, at 331, and Keane, "Legal Problems of Surrogate Motherhood", [1980] S. Ill. U.L.J. 147, at 157-58.

Notwithstanding this divergence of views, it bears emphasizing that we are in agreement respecting the fundamental principle that all payments relating to a surrogate motherhood agreement must receive the prior approval of the court. We believe that mandatory judicial control over payments is an effective answer to the concerns that have been voiced in connection with payment of the surrogate mother. In particular, we are of the view that this prophylactic measure will reveal any financial exploitation of a surrogate mother by the prospective social parents. Accordingly, we recommend that legislation should provide that no payment may be made in relation to a surrogate motherhood arrangement without the prior approval of the court.

c. *Birth of a Handicapped Child*

In the discussion about surrogate motherhood, as reflected in the literature and certain written submissions made to this Commission, concern has been expressed about the possibility that a handicapped child will be born for whom neither the surrogate mother nor the social parents wish to assume responsibility. This concern, however, appears to have little basis as a matter of law. In Ontario, parents of an infant are legally responsible for its welfare, irrespective of their particular preferences. Should the parents decline to fulfil their responsibilities to the peril of the child, the children's aid society will intercede, and the parents will be required to discharge their duty to provide financial support.

Under our proposals, legislation will provide that, upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents will be the parents of the child for all legal purposes.[382] Accordingly, the social parents will be responsible for the child, whatever its condition. While the legislation will assure certainty of parentage for a handicapped child, however, it will no more guarantee that parental responsibility will be assumed willingly than does the present law for handicapped children whose conception is natural. If the social parents do not wish to accept custody of the child, they cannot be compelled to do so as a matter of law or as a practical matter, and the children's aid society will undoubtedly intervene.

No special provision, then, need be incorporated in surrogate motherhood agreements to address the ultimate legal responsibility in the event of the birth of a handicapped child. It follows from our resolution of the issue of parentage.

---

[381] Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from the recommendation in favour of regulating surrogate motherhood arrangements: see Vice Chairman's Dissent, at page 287 of this Report. However, if such a procedure were adopted, Dr. Leal would require that no payments be made to a surrogate mother without the prior approval of the court, and would limit the items for which payment may be made to medical and similar costs and related out-of-pocket expenses.

[382] See *infra*, this ch., sec. 5(e)(v), where the status of the child is discussed.

A related issue, however, would appear to warrant attention in a surrogate motherhood agreement. As a practical matter, it would appear advisable that the parties be required to resolve how a handicapped newborn is to be medically managed. Since circumstances may arise suddenly, demanding immediate resolution, provision should be made for the allocation of the power of decision. A decision concerning who is to bear responsibility is of particular significance in the case of the birth of a seriously impaired child whose surgical or other medical care may require parental consent, as neither the surrogate mother nor the intended social parents may have a commitment to the child's survival.

Under the present law, parents are bound to provide their children with the necessaries of life[383] and with medically advised treatment,[384] so that a refusal to consent to ordinary medical care is controlled.[385] Refusal of ordinary care will justify involvement of the local children's aid society, which may consider bringing protection proceedings in order to achieve such supervision of the child as will result in consent being given to his or her care. Moreover, the child's medical attendants may have the authority to take life prolonging rescue measures on behalf of the child without the consent of the parent.[386]

Where aggressive or extraordinary care is in issue, however, parents are under no legal duty to consent to treatment, but have a discretion to do so; such care may be declined in favour of conservative or palliative care, which may not have the effect of preventing death. While that decision — in effect to allow the child to die — is lawful *per se*, it may be offensive where it seems to be based upon the parents' preferences for themselves, rather than upon a perception of the interests of the child. Circumstances may exist in which refusal of extraordinary care may be legally proper,[387] but the refusal appears more acceptable when coming from a person or agency unaffected by any possible conflict of interest.

The birth of a handicapped child in the context of a surrogate motherhood arrangement would be governed by the abovementioned principles. Hence, with respect to ordinary care necessary to preserve the life of the child, there would appear to be no problem: in the face of a parental refusal or inability to consent, the children's aid society might be notified or the attending physicians might take the requisite measures. Nonetheless, it would be helpful if the parties were to stipulate in their agreement who is to have the power to give consent if the social parents are unavailable.

---

[383] *Criminal Code*, *supra*, note 187, s. 197(1)(a).

[384] *Child Welfare Act*, *supra*, note 41, s. 19(1)(b)(ix). See the *Child and Family Services Act, 1984*, *supra*, note 41, s. 37(2)(e).

[385] See Dickens, "The Right to Natural Death" (1981), 26 McGill L.J. 847.

[386] *Ibid.*, at 856-62.

[387] See *Re Superintendent of Family and Child Service and Dawson et al.* (1983), 145 D.L.R. (3d) 610 (B.C.S.C.). For commentary, see Dickens, "Medicine and the Law — Withholding Paediatric Medical Care" (1984), 62 Can. Bar Rev. 196.

More difficult is the question of extraordinary care. If parental consent to such treatment is not forthcoming, the infant will die. While the present law does permit such a result, we believe that, in this context, it should not be allowed to occur by default, for instance, through the inability to notify the social parents. In our view, the parties should be required to address this possibility and arrive at a resolution in their agreement. For example, the agreement might stipulate that, if extraordinary care offers the only hope to save the life of the newborn infant, the power of decision should be delegated to the surrogate mother or to the attending physician. Alternatively, it might be provided that extraordinary care, if available, should be declined, with the power to refuse such care delegated to the surrogate mother.

We realize that the issues associated with the medical care of handicapped infants are profound and extend far beyond the bounds of this Reference. We believe, however, that the conditions of parental choice that prevail under the present law should apply also in this context. Accordingly, we recommend the court should be required to ensure that a surrogate motherhood agreement contains adequate provision dealing with the allocation of the power of decision relating to the medical care of a newborn handicapped child and with the nature of that decision.

d. Abortion and the Surrogate Mother

In the debate about the propriety of surrogate motherhood, some concern has been expressed about the possible impact of allowing these arrangements on the incidence and availability of abortion. This question has been raised by both those who oppose abortion and those who wish to preserve the availability of abortion. The former have argued that surrogate motherhood arrangements may lead to abortions if the results of prenatal testing disappoint the prospective social parents by, for example, revealing a birth defect. The latter have indicated a concern that the involvement of the surrogate mother in the agreement not limit the rights that she has under the law to seek an abortion, irrespective of the wishes of the social parents.

Although virtually all the discussion has concerned induced abortion, this emphasis disregards the possibility that a surrogate mother may suffer a spontaneous abortion during the pregnancy.[388] By definition, spontaneous abortion does not raise the contentious moral and legal issues that are associated with induced abortion. Accordingly, we see no reason to make a substantive recommendation in relation to it. We anticipate that the possibility of its occurrence would be addressed in the surrogate motherhood agreement, which might provide for the reimbursement of any expenses advanced in anticipation of a birth.

The question of induced abortion is more relevant in the United States, where the United States Supreme Court has held that a woman has an absolute right to abortion in the first trimester of pregnancy.[389] In view of the present

---

[388] For a brief discussion of the incidence of spontaneous abortion, see *supra*, ch. 2, note 4.

[389] See *Roe v. Wade*, 410 U.S. 113 (1973).

Canadian law respecting the availability of abortion, we need only canvass this undeniably difficult issue in a very cursory manner.

Under the present law, induced abortion is lawful in Canada only where continuation of the pregnancy would or would be likely to endanger the pregnant woman's life or health.[390] It is envisaged that the terms of the agreement would address the possibility that conditions may arise that justify an abortion in accordance with the *Criminal Code*.

However, leaving the matter to be addressed in the agreement only resolves in part the legal issues arising in connection with induced abortion in this context. Where a surrogate mother plans to seek a therapeutic abortion, the prospective social parents may prefer that she honour her promise to bear and deliver a child. A question therefore arises concerning whether, notwithstanding that the child to be born may have no genetic relation to either of the social parents,[391] they should be able to challenge the surrogate mother's decision before the therapeutic abortion committee or before a court, on the ground that no danger exists to her life or health. Needless to say, there is no jurisprudence bearing precisely on this question. However, while it has been held that a husband has no right to preclude a lawful abortion planned by his wife,[392] his standing to challenge the legality of the abortion has been recognized.[393] How these principles would be applied by the courts in this context remains to be seen.

Difficulties might arise also if an abortion were to be sought outside Canada. For example, in their agreement, the parties might contemplate recourse to abortion in another country, and it would be the responsibility of the court to determine whether such a term should be approved. In the absence of prior agreement concerning this matter, the social parents might seek a remedy against the surrogate mother if an abortion were sought outside Canada on grounds other than those stipulated in the *Criminal Code*.

We are of the view that it is inappropriate to make a proposal respecting the possibility of abortion. There is a body of developing jurisprudence concerning the right of a woman to pursue an abortion lawfully and the exercise of that right in relation to the assertion of other claimed rights, and we prefer to leave the issue to be resolved within that larger context.

---

[390] *Criminal Code*, *supra*, note 187, s. 251(4)(c).

[391] If, for example, the surrogate mother were artificially inseminated by donor semen, this would be the case.

[392] See *Whalley v. Whalley* (1981), 122 D.L.R. (3d) 717 (B.C.S.C.), and *Paton v. Trustees of BPAS and Another*, [1979] Q.B. 276, [1978] 2 All E.R. 987.

[393] See *Medhurst v. Medhurst* (1984), 46 O.R. (2d) 263, 9 D.L.R. (4th) 252 (H.C.J.), *per* Reid J., jud. rev. denied, *Re Medhurst and Medhurst* (1984), 45 O.R. (2d) 575, 7 D.L.R. (4th) 335 (H.C.J.).

e. Residual Terms of Surrogate Motherhood Agreements

The regulatory scheme that we have proposed requires the court not only to approve the participation of the prospective parties, but also to approve the specific terms of their agreement. It will be the responsibility of the court to ensure that the agreement adequately protects the child and the parties and does not include any inequitable or unconscionable terms that would offend against the public interest.[394]

In previous sections, we discussed whether, and how, the approved surrogate motherhood agreement should address certain very controversial matters. In this section, we shall enumerate a number of important issues that we believe should be addressed by the parties in settling the terms of such an agreement.[395] The parties will be required to direct their minds to these questions and to resolve them. While they may include in the agreement terms to deal with one or more of these issues, they may conclude that it is unnecessary to do so. Whatever their decision, it will be subject to the approval of the court, which must be satisfied that the agreement is fair and equitable to all concerned.

Accordingly, we recommend that, while the parties to a surrogate motherhood agreement should be free to introduce terms of their choosing, they should be required to consider, and agree upon a resolution of, the following issues:

1. health and life insurance protection for the prospective surrogate mother;
2. arrangements for the child should the intended social father or mother, or both, die before the birth of the child;
3. arrangements for the child should the intended social parents cease to live together as a couple;
4. circumstances regarding the particular manner in which immediate surrender of the child to the social parents is to be effected;
5. the right, if any, of the surrogate mother to obtain information respecting, or to have contact with, the child after surrender;
6. prenatal restrictions upon the surrogate mother's activities before and after conception, including dietary obligations;
7. conditions under which prenatal screening of the child may be justified or required, for example, by ultrasound, fetoscopy, or amniocentesis.

In requiring parties to address these issues, we would not require that they reach particular conclusions, provided that the court is satisfied that the ultimate resolution of each issue is in the interests of the child and is otherwise fair and equitable. Indeed, provided that the parties have considered a particular issue, they might not be required to include in the agreement a term relating to that issue. In the circumstances, the courts might find a failure to include such a term quite acceptable. Alternatively, the court might direct that a term resolving the specific issue be included in the agreement.

---

[394] See *supra*, this ch., sec. 5(d).

[395] For an example of a surrogate motherhood agreement, see Brophy, "A Surrogate Mother Contract to Bear a Child" (1981-82), 20 J. Family L. 263.

(v) Status and Inheritance Rights of the Child

Thus far, we have sought to protect the best interests of the child by making recommendations relating to the various actors whose participation is required under the proposed scheme. In this section, we shall make specific recommendations bearing directly on the child.

We have explained that, upon birth of the child, custody will be given to the approved social parents. In order that the child will rest securely in its new environment, its status and parentage should be established in law with certainty, as was the case with respect to children born as a result of artificial conception technologies.[396] We recommend that, upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents should be recognized as the parents of the child for all legal purposes and the surrogate mother should have no legal relationship to the child.

In a previous section, we proposed that a power should be conferred on the court, upon the application of the surrogate mother or the children's aid society prior to the birth of the child, to review the agreement and, if necessary, to rescind it.[397] Where the agreement has been rescinded, the social parents would not become the legal parents. However, a problem may arise where a child is born prematurely, after the application for review has been made, but before the court has determined the matter. In anticipation of such circumstances, we recommend that, where the court subsequently rescinds the agreement, it should be given the power to make an order providing that the social parents are not to be recognized in law as the parents.

Leaving aside this relatively arcane problem, we believe that two further recommendations should be made in order to ensure certainty of parentage. Similar proposals have been made earlier in this chapter in connection with the artificial conception technologies.[398]

First, we recommend that the birth of a child in consequence of an approved surrogate motherhood arrangement should be registered under the *Vital Statistics Act*[399] showing the social parents as the mother and father. The surrogate mother should not be named in the register of births; nor should the fact that the child has been born to a surrogate mother appear in the register.

---

[396] See *supra*, this ch., sec. 3(d)(i).

[397] See *supra*, this ch., sec. 5(e)(iv)a.

[398] See *supra*, this ch., secs. 3(d)(iii) and (iv).

[399] *Supra*, note 123.

Secondly, we wish to address the question of the inheritance rights of the child. While our recommendation that the social parents of a child born pursuant to an approved agreement should be recognized for all legal purposes as the parents of the child should dispose of the matter of inheritance, in order to clarify this beyond peradventure we recommend that such children should acquire inheritance rights through the approved parents. We should add that, consistent with our recommendation respecting status and parentage, the child should have no inheritance rights against the estate of the surrogate mother simply by virtue of the biological relationship. However, this would not prevent the surrogate mother from making a specific bequest to the child in her will.

(vi) Agencies Arranging Surrogate Motherhood Agreements

In the United States, notwithstanding the unclear legal status of surrogate motherhood arrangements and the opposition of certain state Attorneys General, there has been a steady proliferation of private agencies offering to bring together prospective social parents and surrogate mothers. Based on this experience, we expect that, if our recommended scheme were implemented, similar liaison services would seek to be established in Ontario. While such services may come to be offered by hospitals or private infertility clinics as part of their treatment of infertility, we anticipate that individuals may attempt to set up agencies to be operated on a commercial basis.

Whether intermediaries should be permitted to function at all within the context of our regulatory scheme is an important question. More significant, however, is the issue whether private profit-oriented agencies should be tolerated. We have already indicated our concern that surrogate motherhood arrangements not be tainted by an offensive commercialism. In this regard, we have recommended that no payment should be made in relation to a surrogate motherhood arrangement without the prior approval of the court.[400] The unregulated operation of private agencies may serve to undermine the integrity of these proposals by introducing a dangerous commercialism through the back door.

An abiding concern about the dangers associated with the intervention of intermediaries is apparent in the regulation of adoption in Ontario under the *Child Welfare Act*. Apart from the local children's aid society, adoptions may be arranged lawfully only by private adoption agencies or by licensed individuals. Private adoption agencies are licensed organizations that are authorized generally to place children for adoption; at present, there are four in the Province. Licensed persons are individuals who receive a licence to place a particular child with a particular couple. These individuals do not have a general authority, similar to that of the private adoption agencies, to place children for adoption.

It must be emphasized that, notwithstanding the appearance of a degree of autonomy, private adoption agencies and licensed persons are subject to rigorous control by the Ministry of Community and Social Services. In the first instance, control is imposed through the requirement of licensing by the Director of Child Welfare. More directly, there is mandatory supervision of individual child placements. As we explained in chapter 4, the *Child Welfare Act* provides that no placement may be effected without the prior approval of the Director of Child Welfare after the completion of a homestudy of the prospective adoptive parents.[401] A further restriction, which is directed to preventing exploitation by the intermediaries, limits the amount that may be charged to an adoptive parent for expenses incurred or services provided in connection with the adoption to a maximum of $1,500. This amount may be increased only by the Director of Child Welfare.[402]

---

[400] See *supra*, this ch., sec. 5(e)(iv)b.

In recent years, as part of its comprehensive study of Ontario legislation affecting children, the Ministry of Community and Social Services has given considerable attention to private adoption.[403] This process has culminated in the new *Child and Family Services Act, 1984*, under which private adoption will continue to supplement public adoption in Ontario.

Against the background of the statutory framework regulating adoption, and in light of the present views of the Ministry of Community and Social Services, we suggest that there may be a place for private agencies to arrange surrogate motherhood agreements. We believe, however, that such agencies should be allowed to operate only under the supervision of the Ministry of Community and Social Services.

At this stage, we prefer to express our general views on this matter, rather than to articulate detailed proposals. Since the Ministry of Community and Social Services has broad experience in the related area of adoption, we believe that it should be given the responsibility of developing policy regulating surrogate motherhood agencies modelled closely on its control of adoption agencies. We anticipate that regulation would deal with the credentials of operators of agencies, the calibre and number of their staff, advertisement and recruitment practices, services offered, and fees charged. An important further safeguard would exist, of course, in the requirement of court approval of the agreements prior to their implementation.

Accordingly, we recommend that the Ministry of Community and Social Services should be required to regulate any agencies that arrange surrogate motherhood agreements.

---

[401] See *supra*, ch. 4, sec. 3(b). With respect to the requirement of the approval of the Director and a homestudy where a licensee is involved under the new *Child and Family Services Act, 1984*, *supra*, note 41, see ss. 135 and 136.

[402] R.R.O. 1980, Reg. 96, s. 44.

[403] See Ontario, Ministry of Community and Social Services, *The Children's Act: A Consultation Paper* (1982), and Ontario, Ministry of Community and Social Services, *The Children and Family Services Act: Draft legislation and background paper* (1983).

(vii) Miscellaneous Issues

a. Failure of Flushing to Remove an In Vivo Fertilized Ovum

Earlier in this Report, we discussed the artificial conception technology involving *in vivo* fertilization followed by removal by lavage of the fertilized ovum for transplantation to the uterus of another woman who intends to retain the child upon birth. We explained that instances may occur where lavage fails to remove the *in vivo* fertilized ovum, resulting in the pregnancy of the intended ovum donor.

In such a case, the intended ovum donor may decide to keep the child.[404] Alternatively, she may be willing to transfer custody of the child to the couple to whom she had intended to donate the ovum. Under the present law, the child and the couple would remain in a state of uncertainty respecting status and parentage.

We suggest that it would be salutary if, upon diagnosis of the pregnancy, the woman were to be allowed to agree with the couple that, upon birth, the child will be surrendered to them, and that she will continue her pregnancy as a surrogate mother. However, in order for such an agreement to be recognized in law, and to establish the legal relationship between the child and the intended parents, the agreement would have to receive judicial approval. Although the court would face a *fait accompli* regarding the commencement of pregnancy, it might usefully review the terms of an abbreviated form of agreement for the purpose of ensuring protection of the interests of the future child and the parties. In appropriate circumstances, notice of the application might be served on the local children's aid society.

It may be argued that this *ex post facto* procedure for judicial approval is not necessary, as the risk of unwanted pregnancy is implicit in this technique of ovum donation and should be anticipated by the parties. Conceivably, legislation might require that, in the case of every ovum donation by means of lavage, participants make an application to the court for approval of a surrogate motherhood arrangement in the event that the ovum donor becomes pregnant. We suggest, however, that subjecting this form of ovum donation to such a costly and cumbersome procedure in anticipation of an event that may not occur would involve an unwarranted expenditure of resources. On balance, we believe that it is preferable to address the problem of pregnancy when it arises, even if this means an expedited process of scrutiny.

On discovery of pregnancy, therefore, proceedings for judicial approval of a surrogate motherhood arrangement would be initiated. Since, due to time constraints, the parties might be unable to agree on all the terms of the agreement, it would be useful to empower the court to settle the terms in respect of which there is disagreement in a manner compatible with the best interests of the child.

---

[404] If the intended ovum donor decides to keep the child, the intended social parents may have no effective recourse. If the male is not the sperm donor, the couple will be in no better legal position in a custody claim than would complete strangers to the child. If the male is the sperm donor, and can prove paternity, he may attempt to claim custody. In addition, should custody be granted to the ovum donor, he would be notified of any proceedings affecting the child if, for some reason, the children's aid society later were to intercede to protect the child. See, for example, *Child Welfare Act*, *supra*, note 41, s. 28(6), and *Child and Family Services Act*, *supra*, note 41, s. 39.

Accordingly, we recommend that, where a woman undergoes *in vivo* fertilization of an ovum intended for donation and becomes pregnant, she and the intended social parents should be able to apply to the court for approval of a surrogate motherhood arrangement in accordance with our previous recommendations. In approving the arrangement, the court should be empowered to determine unresolved terms of the agreement where all parties have approved the terms in principle, but have been unable to settle the details thereof by the time that the application for approval is presented.

b. Introduction of Replacement Surrogate Mothers

After a surrogate motherhood arrangement has received judicial approval, the surrogate mother may become medically or otherwise unsuitable or unwilling to undertake her role prior to the performance of the particular artificial conception technique. In view of their obvious emotional interest and the investment of human and material resources, the prospective social parents may attempt to find a replacement, conclude an agreement, and seek judicial approval.

Where conception is to be effected by means of artificial insemination, finding a replacement surrogate mother will not be urgent. Where, however, an ovum has been fertilized *in vitro* or *in vivo*, and it was intended to transfer it to a proposed surrogate mother who has become unavailable, finding a suitable replacement will be a matter of considerable urgency, because a delay in transferring the fertilized ovum may mean its wastage. In these circumstances, our recommended scheme, requiring comprehensive judicial scrutiny of the parties to any agreement, may so postpone transfer of the fertilized ovum that its destruction will be assured. Although embryo freezing may ease time pressures to find a replacement, the thawing process may result in loss of the fertilized ovum.

We suggest that, in view of the expense incurred in preparation for the transfer of the fertilized ovum to the approved surrogate, the special status some accord the fertilized ovum, and, where the ovum donor is an intended social mother unable to bear a child, the special interest she may have in the ovum when her capacity for future ovulation is impaired, its avoidable wastage should not be contemplated casually.

While it may be argued that withdrawal of the approved surrogate mother is an inherent risk that is accepted by the social parents, when balanced against the factors that we have delineated above we see little of value in requiring them to initiate the entire procedure once again.

We believe that, where an approved surrogate mother who is the intended recipient of a fertilized ovum becomes unavailable, there should be a summary procedure to hear an application to add a replacement. In the earlier hearing of the application, the intended social parents will have been approved as suitable for participation, and it is this appraisal that is most critical to the protection of the interests of the unborn child. On the second, expedited hearing, there will be no need to reassess the social parents, and owing to the exigencies of the situation, the suitability of the replacement surrogate mother may properly be assessed in a summary manner.

One consequence of an abbreviated procedure may be that approved surrogate mothers, aware of the possibility that they may be replaced in this manner, may feel free to withdraw from agreements should they have doubts about their commitment. We do not regard this as undesirable: prior to conception, surrogate mothers should not feel constrained to honour their promises if, in fact, they wish not to participate.

Accordingly, we recommend that, where an approved surrogate mother who is the intended recipient of a fertilized ovum becomes unavailable, there should be a summary procedure for the approval of a replacement surrogate mother, where this is necessary to secure transfer of the fertilized ovum in order to avoid its wastage.

c. Recognition of Surrogate Motherhood Agreements Made Outside Ontario

While we have proposed a scheme to regulate surrogate motherhood arrangements in Ontario, we recognize that the proximity of the United States and the existence there of private agencies willing to arrange surrogate motherhood transactions may attract prospective social parents from Ontario. Whether, and the extent to which, there will be recourse to these agencies will depend on the response of American jurisdictions to this phenomenon and on the availability of services in Ontario. Should the demand for services in this jurisdiction be met effectively, and if the degree of regulation is considered fair, and not excessively rigorous, it is less likely that Ontario couples will seek assistance elsewhere. Since the effect of regulation cannot be predicted, we believe that the issue of the recognition to be given to surrogate motherhood agreements that are made out of the jurisdiction must be addressed in this Report.

Where children are born and their births are registered outside the jurisdiction, and where the courts of other jurisdictions have approved adoption of children by Ontario residents,[405] no issue arises in connection with the effect in Ontario of the surrogate motherhood agreement. Under the existing law, the adoption will be accorded recognition in Ontario[406] and, assuming that the parents are citizens of Canada or permanent residents, they should not encounter difficulty in the immigration of the infant to Canada.[407]

---

[405] Whether a couple resident in Ontario will be allowed to adopt a child in the United States will depend on the residency requirements of the particular state.

[406] Section 87(1) of the *Child Welfare Act*, *supra*, note 41, provides that an adoption made according to the law of another province or territory of Canada or of any other state or

Where, however, a surrogate motherhood agreement is entered into outside Ontario and the birth is to take place or actually does take place in Ontario, the question whether recognition should be extended to that agreement must be considered. If recognition is not given, the agreement will have no legal effect in Ontario. Consequently, the parties to an extraprovincial agreement will be in no better position than they are under the present law, or if they were to make an agreement in Ontario in disregard of the proposed scheme.[408]

If, by chance, a child is born to a surrogate mother in Ontario, perhaps in premature labour, where none of the parties to the surrogate motherhood agreement has a significant connection with the Province, the matter is of little consequence in the Province, and may be treated according to the proper law of the agreement. Of greater concern, however, are planned evasions of Ontario requirements, in which surrogate motherhood agreements, lawful where made, but in violation of Ontario law, are implemented deliberately in the Province. This may be advantageous if the requirements in another jurisdiction are more lenient than those under our proposed scheme, particularly where the scrutiny of prospective parents and control over payments are less stringent.

There may be a certain appeal in a legislative response to this problem that provides for recognition of extrajurisdictional agreements only insofar as they are compatible with, or not fundamentally offensive to, Ontario law.[409] Such an approach would allow courts to determine whether offensive provisions were severable, or whether the whole agreement should be denied recognition. This solution, however, may fail to address key questions pertaining to the welfare of children born pursuant to agreements containing offensive aspects.

For the present, we are persuaded that the better approach is to leave any problems that may arise to be resolved by the courts. Guidance may be sought in

---

country or part thereof shall have the same effect in Ontario as an adoption under the *Child Welfare Act*. See, also, the *Child and Family Services Act, 1984*, *supra*, note 41, s. 153.

[407] If a child is born in the United States to a surrogate mother who is not a Canadian citizen, and it can be proved that the social father, a Canadian citizen, is indeed the biological father, the child will have a right to enter Canada because he or she will also be a Canadian citizen: see s. 6(1) of the *Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, which is itself Schedule B of the *Canada Act 1982*, c. 11 (U.K.); *Immigration Act, 1976*, S.C. 1976-77, c. 52, s. 4; and *Citizenship Act*, S.C. 1974-75-76, c. 108, s. 3(1)(b). In such a case, adoption would be irrelevant to the right of the child to enter Canada. Where the social father is not the biological father, or where he or his spouse is a permanent resident, an application for landing can be made after the adoption.

[408] For the consequences of making a surrogate motherhood arrangement in violation of the proposed regime, see *infra*, this ch., sec. 5(e)(viii).

[409] For an example of a legislative response in another context, see *Family Law Reform Act*, *supra*, note 127, s. 57.

the existing body of private international law and family law dealing with the recognition of foreign agreements involving residents of Ontario, where such agreements contain elements inconsistent with public policy in the Province. However, if the courts cannot resolve problems of surrogate motherhood agreements made outside Ontario so that the interests of children are protected, or if the courts pursue inconsistent approaches leading to uncertainty, remedial legislation may be necessary.

Accordingly, we recommend that, for the initial period during which surrogate motherhood agreements are regulated by statute, no specific provision should be enacted to address the question of such agreements that are made outside Ontario and intended for implementation in the Province.

d. Medical Records

In our discussion of the issues common to all the artificial conception technologies, we expressed the view that legislation was not necessary to compel the maintenance of medical records by physicians, as this was required pursuant to regulations made under the *Health Disciplines Act*.[410] Similarly, in this context, we believe that no legislation need be enacted to address the maintenance of such records, and, accordingly, we make no recommendation in regard thereto.

(viii) Failure to Comply with the Proposed Scheme

We have recommended a comprehensive regulatory regime designed to give legal recognition and effect to surrogate motherhood agreements that receive the approval of the court. However, for various reasons, there may be persons who choose to enter surrogate motherhood arrangements outside the proposed regulatory scheme. Perhaps a couple may fear that they will not receive judicial approval. We need not dwell unduly on the range of motivating factors; suffice it to say that the possibility that persons may seek to evade the regulatory scheme does concern us. In this section, we shall consider appropriate responsive measures.

a. Penalties

One effect of surrogate motherhood arrangements for which approval is not sought under the proposed regime or that are pursued in disregard of judicial disapproval is that they will remain unenforceable and the persons affected will be uncertain as to their rights and responsibilities until a judicial determination of them.[411]

A scheme of statutory control that is designed to be actively regulatory, however, demands a sanction beyond mere ineffectiveness of agreements made in defiance of it. Merely rendering contracts unenforceable may not be sufficient to discourage unauthorized agreements from being concluded and being performed voluntarily by the parties. A stronger deterrent is warranted. If unauthorized surrogate motherhood arrangements are to be actively prohibited, a provincial offence should be created for which there would be liability to a penalty.

---

[410] R.R.O. 1980, Reg. 448.

[411] With respect to the status of children of unapproved surrogate motherhood arrangements, see the following section of this chapter.

Subject to an exception, to be discussed below, the essence of the offence should be participation in a surrogate motherhood arrangement that a person knows or believes is intended to evade the proposed scheme of regulatory control.[412] We believe that liability for violation of this prohibition should be visited on all persons involved in the impugned arrangement — the parties, their advisors, and any intermediaries who may have brought them together.

In proposing that the parties to an illegal arrangement be rendered liable to a penalty, we differ from certain other bodies that have considered this issue. The Warnock Committee recommended that legislation render criminal "the creation or the operation ... of agencies whose purposes include the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wish to utilise the services of a carrying mother".[413] It recommended that this legislation embrace "the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy".[414] The Warnock Committee, however, did not wish to impose criminal liability on the parties to the prohibited arrangement, explaining that it was "anxious to avoid children being born to mothers subject to the taint of criminality".[415]

The Queensland Report took the view that, while "surrogacy arrangements" should not be made criminal offences, "it should be made illegal to advertise to recruit women to undergo surrogate pregnancy, or to provide facilities for persons who wish to make use of the services of such women".[416]

The recently enacted Victoria *Infertility (Medical Procedures) Act* 1984[417] has taken a different approach, imposing criminal liability on both intermediaries and parties. Section 30(2) provides as follows:

---

[412] It would not be necessary in the surrogate motherhood context to provide a penalty for the performance of the artificial conception procedure by other than medically trained persons. We have already recommended the enactment of legislation providing that artificial conception procedures constitute the practice of medicine, which would make it an offence for such procedures to be undertaken by anyone other than a licensed physician or someone under the latter's supervision or direction: see *supra*, this ch., sec. 3(a).

[413] Warnock Report, *supra*, note 2, para. 8.18, at 47.

[414] *Ibid*.

[415] *Ibid*., para. 8.19, at 47.

[416] Queensland Report, *supra*, note 2, at 117-18.

[417] *Supra*, note 48.

30.-(2) A person shall not—

(a) publish, or cause to be published, a statement or an advertisement, notice or other document that—

(i) is intended or likely to induce a person to agree to act as a surrogate mother;

(ii) seeks or purports to seek a woman who is willing to agree to act as a surrogate mother; or

(iii) states or implies that a woman is willing to agree to act as a surrogate mother;

(b) make, give or receive, or agree to make, give or receive, a payment or reward for or in consideration of the making of a contract, agreement or arrangement under which a woman agrees to act as a surrogate mother; or

(c) receive or agree to receive a payment or reward in consideration for acting, or agreeing to act, as a surrogate mother.

We seek to prevent the subversion of our proposed scheme not only by self-interested intermediaries, but also by the prospective parties to the agreement. In this respect, we derive support from the Victoria legislation and the Ontario *Child Welfare Act*. The latter statute imposes penalties for breach of certain prohibitions on persons who seek to become the adoptive parents of a child, but, in doing so, act in violation of the legislation.[418] The purpose of providing for such liability is to deter them from ignoring a regulatory scheme that has as its primary purpose the protection of the best interests of the children to be served thereby. At its heart is a subordination of the wishes of the prospective parents to the interests of the child.

We have indicated our view that, in principle, there should be a penalty for participation in a surrogate motherhood arrangement where it is known or believed that the arrangement is intended to evade our proposed regulatory scheme. Where, however, a professional is confronted with a *fait accompli* — for example, where an obstetrician is asked to deliver a pregnant surrogate mother's baby, or where a psychologist is asked to counsel a pregnant surrogate mother — he or she should not be deterred from assisting by the existence of a penalty. Indeed, intervention may serve to alleviate the harmful effects of the agreement on the parties or the child.[419] Accordingly, the recommended penalty would not attach to all forms of participation in a surrogate motherhood arrangement, but only to actions directed to the evasion of our proposed scheme.

We believe that the severity of the penalty is of less importance than the fact of its existence. Generally speaking, violations of provincial offences tend to render the offender liable to relatively modest fines and to relatively brief periods of imprisonment. However, we do observe that, where legislation concerns the protection of children, the Legislative Assembly of Ontario has been willing to impose somewhat more onerous penalties. Under the *Child Welfare Act*, a person who places or receives a child for adoption in contravention of the Act may be liable to a fine of not more than $2,000 or to imprisonment for a term of not more than two years, or both.[420] A person who violates the prohibition against making, offering, or receiving payments in connection with adoption is liable to a fine of up to $5,000 or imprisonment for three years, or both.[421]

---

[418] *Child Welfare Act*, *supra*, note 41, s. 94(2)(b) and (5). See the *Child and Family Services Act, 1984*, *supra*, note 41, s. 160(2).

[419] We observe that, while the resolution approved by the Council of the British Medical Association in March, 1984, stated "that it is unethical for a doctor to become involved in techniques and procedures leading to surrogate motherhood", it declared also that "[t]his statement does not, however, affect the duty of care of the doctor to any woman who has conceived under these circumstances": see B.M.A. Annual Report, *supra*, note 303.

We suggest that it would be inappropriate to provide for incarceration of prospective parents who seek to avoid the proposed regulatory scheme. Such persons may be considered misdirected in their efforts, but not so inherently vicious as to warrant imprisonment. Moreover, where they have already obtained custody of an infant pursuant to an unapproved arrangement, incarceration would hardly be in the best interests of the child. Similarly, we regard the incarceration of health care and other professionals as a disproportionate response.

In accordance with these views, we recommend that a penalty of a fine should be provided for participation in a surrogate motherhood arrangement where it is known or believed that the arrangement is intended to evade the proposed regulatory scheme. However, where a professional whose assistance is sought is confronted with a *fait accompli* — for example, where an obstetrician is asked to deliver a pregnant surrogate mother's baby — he or she should not be subject to the proposed penalty for giving such assistance.

b. Status of Children of Unapproved Surrogate Motherhood Arrangements

Our previous recommendation, favouring the establishment of a penalty for violation of the proposed legislation, addresses only one of the questions raised by the possibility of evasion. The other major issue, which is no less important, particularly in light of this Project's Terms of Reference, concerns the effect of evasion on the status of a child born pursuant to an unapproved surrogate motherhood arrangement.

As we have explained earlier,[422] under certain circumstances, existing law may be utilized to regularize the relationship of the infant and the couple who wish to be recognized in law as its parents. In this way, the objectives of a surrogate motherhood agreement may be realized by the parties, although not as a function of the agreement itself. The particular procedures available will depend on the genetic parentage of the child.

---

[420] *Child Welfare Act*, *supra*, note 41, s. 94(2)(b). See the *Child and Family Services Act, 1984*, *supra*, note 41, s. 160(1) and (2).

[421] *Child Welfare Act*, *supra*, note 41, s. 94(5). See the *Child and Family Services Act, 1984*, *supra*, note 41, s. 160(4).

[422] See *supra*, this ch., sec. 5(a).

Upon birth of the child, the surrogate mother will be its mother in law. If she is married and living with her husband at the time of conception, he will be registered as the father.[423] Where the intended social father is the sperm donor, he may establish his paternity and seek to obtain sole custody in proceedings brought under Part II of the *Children's Law Reform Act.*[424] His wife may then seek to adopt the child by using the procedures for step-parent adoption. The surrogate mother must consent to the adoption, unless the court makes an order dispensing with her consent.[425] It will be recalled that, in the case of a step-parent adoption, there is no requirement of a homestudy. While, on the hearing of the application for an order for adoption, the court has power to require a report on the adjustment of the child in the home, it need not do so.

If the social father is not the biological father of the child born pursuant to an unapproved surrogate mother arrangement, regularization of the child's status would be by way of a stranger adoption. At present, where a couple wishes to adopt a child who has not been placed for adoption with them under the *Child Welfare Act,* but who nonetheless resides with them, they may make use of the Act *ex post facto* and seek an order for adoption. The practice in such a case is that they find a person to apply for a private licence to place the child with them. The licensee is responsible for arranging a homestudy and for submitting the necessary reports about the persons wishing to adopt the child. The surrogate mother and her spouse, if any, will have to consent to the adoption, unless the court dispenses with their consent.

A question arises as to whether parties who have deliberately, or even inadvertently, ignored the recommended scheme should be allowed to realize their intentions indirectly by means of existing legislation. At first blush, it may appear objectionable that actions taken in violation of our proposed scheme should meet with success, however cumbersomely achieved. Yet, such a perspective, while perhaps understandable as a visceral response, should not prevail. We suggest that the child's best interests would be served by giving certainty to its relationship with the social parents, notwithstanding the fact that this may produce the precise result sought in the impugned arrangement. To deny the social parents the opportunity of regularizing their relationship with the child, as a means of discouraging unapproved arrangements, would have the effect of punishing children for the conduct of their parents.

We believe, therefore, that social parents who acquire custody of children pursuant to unapproved surrogate motherhood arrangements should be allowed to utilize existing procedures to establish their parentage in law after the fact, and we so recommend. However, we would impose upon the social parents a requirement that may not apply under existing law. In our view, whenever social parents seek to utilize existing procedures to regularize the status of a child born outside our proposed scheme, the local children's aid society should be required to submit a homestudy to the court. Had the social parents proceeded according to the recommended scheme, the court asked to approve the surrogate motherhood arrangement would have received evidence respecting their suitability.[426] A court requested to issue an order for adoption after the child has been transferred should not make a decision respecting the status of the child with less information than it would have had if the law had been observed.

---

[423] *Vital Statistics Act, supra,* note 123, s. 6(4) and (5).

[424] *Supra,* note 122.

[425] Where the social father has obtained an order declaring that he is the father of the child, it will, of course, be unnecessary to obtain the consent to the adoption of the husband of the surrogate mother, who is a stranger to the child.

It should be appreciated that, while an unfavourable homestudy may persuade a court to refuse to issue an order for adoption, it will not necessarily result in removal of the child from the home. Seizure of the child will take place only where it is justified under the existing law, that is, where the child is "in need of protection" within the meaning of the *Child Welfare Act*.

Accordingly, we recommend that, where social parents seek an adoption order in relation to a child who is born pursuant to an unapproved surrogate motherhood arrangement and transferred to them, notice of the application should be served upon the appropriate children's aid society. Upon receipt of the notice, the children's aid society should be required to conduct a homestudy and submit to the court a report in relation thereto.

6. FURTHER REVIEW

In this Report, we have sought to respond to the many difficult legal issues that have been created by the advent and continuing refinement of the artificial conception technologies. Our task has not been an easy one. The relevant technologies are developing at an ever increasing rate, raising novel legal issues involving fundamental moral and ethical concerns that have long perplexed man. Hence, we are not hesitant to acknowledge that it is most unlikely that law reform proposals in this area will be blessed with perfect prescience. Given the context, the recommendations must necessarily contain some speculative and experimental aspects.

In view of the unavoidably tentative character of several of our proposals, we suggest that, some time after our recommended scheme has been implemented, a review of its efficacy should be undertaken. This will allow refinement of the elements of the regime, or indeed fundamental amendment, should the latter prove to be necessary. It will also facilitate an appraisal of the response of the College of Physicians and Surgeons of Ontario and individual members of the medical profession.

At this stage, we do not wish to suggest which particular body should undertake this review. The task might be given to the Ontario Council of Health, the Ministry of Community and Social Services, the Ministry of Health, an interministerial committee, or an *ad hoc* committee, which might be composed of representatives of various ministries and other interested bodies. We consider it unnecessary to establish a standing committee of the Legislative Assembly of

---

[426] See *supra*, this ch., sec. 5(e)(i).

Ontario to monitor the effects of our proposals, since a number of ministerial and other bodies are likely to maintain an interest in developments. Moreover, while a central ministerial repository of data might be useful, and might receive information from various ministries dealing with issues of health, family and child welfare and, for instance, vital statistics, we do not believe that the creation of a new governmental monitoring or data gathering agency is warranted. As we have suggested, much of the relevant information will be compiled by interested ministries and agencies, and can be submitted to the body charged with the responsibility of conducting the review.

We therefore recommend that, five years after our proposed regime has been implemented in whole or in part, a review of all aspects of the regime should be undertaken by an appropriate governmental body.

SUMMARY OF RECOMMENDATIONS

The Commission makes the following recommendations:

THE PROPRIETY OF ARTIFICIAL CONCEPTION TECHNOLOGIES

1. Artificial conception technologies, that is, artificial insemination, *in vitro* fertilization, and *in vivo* fertilization followed by lavage, should continue to be available and accepted as legitimate techniques to be used (except where a fertile and genetically healthy single woman receives treatment: see Recommendation 5) where medically necessary to circumvent the effects of infertility and genetic impairment.

2. (1) The use of the new artificial conception technologies should be subject to the recommendations proposed below.

   (2) Unless otherwise stated, the recommendations proposed below should not apply to artificial insemination where the sperm used is that of the recipient woman's husband or partner (A.I.H.).

GENERAL RECOMMENDATIONS FOR REFORM

3. Legislation should expressly provide that artificial conception procedures, that is, artificial insemination (including A.I.H.), *in vitro* fertilization, and *in vivo* fertilization followed by lavage, constitute the "practice of medicine" under the *Health Disciplines Act*.

4. Physicians should not be required to obtain a special licence or to practise in a specially licensed health facility in order to perform artificial conception procedures.

* 5. Eligibility to participate in an artificial conception programme should be limited to stable single women and to stable men and stable women in stable marital or nonmarital unions.

6. The proposed criteria for participation in an artificial conception programme (see Recommendation 5) should be set out in regulations made under the *Health Disciplines Act*.

7. Given the present variety of means by which grievances may be redressed, no additional or different means of challenge or appeal should be made available to a person who is denied access to artificial conception services.

8. Subject to Recommendation 9, legislation should remain silent on criteria for the selection of gamete donors. Questions of reproductive history, marital status, and genetic and other medical status should be left to professional standards to be set by the medical profession.

---

* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from this recommendation: see Vice Chairman's Dissent, at page 287 of this Report.

9. Having regard to recent federal initiatives respecting the setting of standards for donor selection, at least in the context of licensed sperm banks, and in the belief that such standards should be uniform across Canada, there should be consultation between the provincial governments and the federal government so that such uniformity may be furthered.

10. The issue of sperm donation by minors should be left to the general law, which now permits such donation.

11. (1) Minors should be prohibited from undergoing any procedure undertaken deliberately to donate ova.

    (2) However, so long as they have given their free and adequately informed consent (see Recommendation 12), minors should not be prohibited from donating ova acquired indirectly as a result of therapeutic surgery, such as a hysterectomy.

12. Legislation should expressly require a donor's free and adequately informed consent as a precondition to the donation or use of his or her gametes.

13. At the time of donation, a donor should be entitled to restrict the use of the donated gamete to a specified purpose. Such a restriction should continue in effect even after the gamete has been used in a fertilization procedure, unless, prior to fertilization, the donor has altered the specified purpose or has indicated that the restriction is no longer to apply.

14. (1) After donation, but prior to the use of their gametes in a fertilization procedure, donors should be entitled either to require their donation to be wasted or returned to them, so that the gametes may not be used for artificial conception, research, or any other purpose.

    (2) A donor's consent to the donation of his or her gametes, given at the time of donation, should remain of legal effect until withdrawn or otherwise altered (see paragraph (1) and Recommendation 13), so that a fresh consent should not be required at each time the gametes are used.

15. (1) Donors of sperm should be allowed to be paid their reasonable expenses. Such payment should be based roughly upon the time and inconvenience involved in the initial screening with a view to recruitment into donor programmes, and the periodic follow-up checking while remaining active donors. However, payment for "discomfort" should not be available. The sum paid should not be so great as to be an incentive to deceive, nor so great as unduly to burden a clinic having to pay for the time of applicants it rejects. In Ontario, existing payments tend to fall within the $25-$50 range, which is acceptable.

    (2) The same principles as those proposed in paragraph (1) should be applied to ovum donors, although payments may prove to be greater where ovum recovery involves invasive procedures, such as laparoscopy, or where a woman's naturally released ovum is recovered nonsurgically, by means of *in vivo* fertilization and lavage.

16. The frequency of employment of individual gamete donors should be left to the professional judgment and ethics of medical practitioners and to the preference of participants in artificial conception programmes.

17. (1) Gamete banks, that is, banks that buy and sell sperm, ova, and embryos, should be permitted to operate on a commercial basis. However, they should be allowed to operate only under licence and under stringent regulations setting standards of operation, with respect, for example, to payment by users to defray reasonable costs and, perhaps, to provide a reasonable profit. They should be operated subject to public accountability or under the auspices of a public organization, preferably on the model of the Canadian Red Cross Society blood donor clinics.

    (2) Having regard to the recent federal initiatives respecting the licensing of sperm banks, there should be consultation between the provincial governments and the federal government so that the goal of uniformity of standards across Canada may be furthered. (See, also, Recommendation 9.)

    (3) Licensed gamete banks should be prohibited from supplying gametes or embryos to any person or agency other than a licensed physician, a hospital or other approved health care facility, or another licensed gamete bank.

18. (1) The use of gametes and embryos imported from outside Ontario should be permitted but should conform to the standards governing gamete banks in the Province. (See Recommendation 17.)

    (2) Having regard to recent federal initiatives in this general area, there should be consultation between the provincial governments and the federal government to ensure that uniform standards in regard to importation of gametes and embryos are established for the whole of Canada. (See, also, Recommendations 9 and 17(2).)

19. (1) For all purposes, a woman bearing a child through artificial conception in order to rear it should be conclusively deemed to be the child's legal mother, and the woman's husband or male partner who consents to the initiation of the artificial conception procedure or procedures (having regard to paragraph (3)) should be conclusively deemed to be the child's legal father.

    (2) A donor of sperm or an ovum should have no legal relationship to the child arising from the fact of donation; in other words, a donor should have no parental rights or duties regarding the artificially conceived child.

    (3) The consent of the husband or partner (referred to in paragraph (1)) should be presumed as a matter of law. However, this presumption should be rebuttable at his instance or at the instance of another person with a legitimate interest.

    (4) The proposed legislation respecting the status and legal parentage of artificially conceived children should be retroactive in effect.

20. With respect to registration of the birth of an artificially conceived child,

    (a) in the case of artificial conception with donor gametes, the woman who bears and intends to rear the child should be registered as the child's mother, and the mother's spouse or partner who, under Recommendation 19(1), is deemed to be the natural father, should be registered as the child's father.

    (b) the gamete donor should not be named in the register of births, nor should the fact of artificial conception appear in such register.

    (c) where a woman gives birth to a child conceived posthumously by means of her deceased husband's or partner's preserved sperm, the woman should be entitled to register the birth showing the deceased as the father of the child.

21. (1) A child conceived artificially with donor gametes

    (a) should acquire inheritance rights to the estates of those persons who are legally recognized as his or her parents (see Recommendation 19), and to the estates of others as if the child was the natural child of such parents, unless the contrary is expressed by the testator, and

    (b) should have no inheritance rights through the gamete donor, unless the donor expressly provides for the child in his or her will.

    (2) A child conceived posthumously with the sperm of the mother's husband or partner

    (a) should be entitled to inheritance rights in respect of any undistributed estate once the child is born or is *en ventre sa mere,* as if the child were conceived while the husband or partner was alive, and

    (b) should be entitled to inheritance rights where the child is born or is *en ventre sa mere* when the time for the ascertainment of possible beneficiaries arrives.

22. (1) Subject to the recommendations that follow, no specific legislation or rules dealing with medical records relating to the provision of artificial conception services should be enacted or established.

    (2) In order to ensure that the legislation and other guidelines respecting medical records are as comprehensive as possible, particularly in light of the proposal to be made in paragraph (3) concerning a system of linkage between donors and recipients, the relevant statutes, regulations, and professional rules should be amended to make it clear that gamete donors are patients for the purposes of record keeping.

    (3) Pursuant to the power given to the Council of the College of Physicians and Surgeons of Ontario under section 50 of the *Health Disciplines Act,* and subject to the approval of the Lieutenant Governor in Council and the prior review of the Minister of Health, the

Council should make regulations that would establish a system of record keeping permitting doctors to link gamete donors with recipients, subject, however, to paragraph (4).

(4) Anonymity concerning the identity of all parties involved in artificial conception — the donor, the recipient, her spouse or partner (if any), and the child — should be preserved in the medical records.

(5) (a) Where a genetic or transmissible defect or disease in a donor or a donor's child becomes known to a doctor, the doctor should be under a duty, imposed by regulations governing the medical profession, to make all reasonable efforts to report all relevant information to any person whose health and welfare the doctor reasonably believes may be affected by it.

(b) Sanctions for the failure to abide by such a regulation should lie in potential civil liability in negligence and in the "professional misconduct" regulations under the *Health Disciplines Act*, rather than in a specific new penalty.

(6) There should be no positive duty on artificial conception practitioners to take steps to ascertain whether conception and birth have taken place or to ascertain the medical status of any child. However, should it be thought necessary or desirable to deal more formally with this matter, any legal obligation to follow up the outcome of artificial conception treatment should be incorporated in the regulations governing the medical profession under the *Health Disciplines Act*.

(7) (a) The decision to disclose to the child the nature of its biological origins or parentage should not be regulated or dealt with by legislation or other formal rules.

(b) The decision concerning access to medical records by the parties involved — the woman, her husband or partner (if any), the child, and the donor — should be left to individual members of the medical profession. However, under no circumstances should any doctor or other person disclose information that could in any way identify the parties.

23. It should be made a provincial offence knowingly to conceal or misrepresent information in offering or agreeing to donate gametes for artificial conception purposes.

24. Legislation should provide that principles of strict liability, and particularly the implied warranties of merchantable quality and fitness for purpose, should not be applied to the direct or indirect donation or supply of gametes or embryos; rather, recovery in such a transaction should be dependent upon general principles of the law of negligence.

25. The claims by a parent known as wrongful conception and wrongful birth claims, and the claims by a child known as wrongful life and dissatisfied life claims, should not be resolved in a study on human artificial reproduction. Rather, these claims should be the subject of a separate

study, in the context of tort law generally, so that an integrated jurisprudence in the area may be adequately developed.

PROPOSALS RELATING TO THE FERTILIZED OVUM OUTSIDE THE BODY

26. There should be no prohibition of the practice of transferring multiple fertilized ova to a woman, regardless of whether the ova are her own or are donated, and, where the ova are donated, regardless of whether a single donor or different donors are used.

27. (1) (a) A fertilized ovum outside the body, produced with the gametes of the intended recipient and her husband or partner, should be under the joint legal control of the man and woman.

    (b) Where one of the couple dies, legal control of the fertilized ovum should pass to the survivor. If both should die, control should pass to the physician, clinic, gamete bank, or other authority that has actual possession of the ovum.

    (c) Where the couple cannot agree concerning the use or disposition of the fertilized ovum, legal control should pass to the physician, clinic, gamete bank, or other authority that has actual possession of the ovum.

    (2) Subject to Recommendation 13, concerning the case where a gamete donor has imposed a restriction on the use of his or her gamete,

    (a) a gamete donor should have no right in law to control the use or disposition of a fertilized ovum to which he or she has contributed genetic material;

    (b) where a fertilized ovum has been produced from donated sperm and a donated ovum, and is not to be transferred to the woman for whom it was originally intended, legal control over the fertilized ovum should reside in the physician, clinic, gamete bank, or other authority that has actual possession of the ovum; and

    (c) where a fertilized ovum has been produced by a donor gamete and a gamete from one spouse or partner of a couple for whom the ovum was originally intended, and is not to be transferred to the woman for whom it was originally intended, legal control over the fertilized ovum should reside in that spouse or partner alone.

28. Legislation should not be enacted to deal with whether a woman or couple should be entitled to obtain information concerning the sex of a fertilized ovum intended to be transferred to the woman.

29. (1) Research and experimentation on a fertilized ovum outside the body should be permitted, subject to the recommendations that follow.

    (2) Research and experimentation involving a fertilized ovum outside the

body should be restricted to research centres approved by the Ministry of Health.

(3) A research centre should be entitled to be approved only where it has established an ethical review committee for the internal screening of research projects. The Ministry of Health should develop minimum requirements respecting the composition and operation of ethical review committees in research institutions.

30. A fertilized ovum that has been the subject of experimentation that has no direct therapeutic purpose in relation to the ovum should not be transferred to a woman.

31. Having regard to the information now available to medical science respecting embryonic development, regulations should provide that no fertilized ovum outside the body should be allowed to develop beyond fourteen days after fertilization. Should the state of medical knowledge at some future date indicate that the fourteen day period is not appropriate, by being either too short or too long, the regulations should be amended.

32. There should be a maximum of ten years for the cryopreservation or similar storage of a fertilized ovum, after which time the storage authority should be under a duty to have the ovum wasted.

33. The question whether, having regard to the rule against perpetuities, a testator should be able to bind property by relation to the birth of a child from a fertilized ovum in cryopreservation at the time of the testator's death (and, therefore, whether such an ovum is a "life in being" under the rule) should be left to judicial, not legislative, resolution.

SURROGATE MOTHERHOOD

* 34. Legislation should be enacted to establish a regulatory scheme governing surrogate motherhood arrangements.

35. Before an artificial conception procedure may be employed in furtherance of a surrogate motherhood arrangement, the approval of the Provincial Court (Family Division) or the Unified Family Court should be obtained in accordance with the proposals made below.

36. All surrogate motherhood agreements should be in writing. The court should be required to approve the terms of the agreement and to ensure that they adequately protect the child and the parties and are not inequitable or unconscionable.

37. On the hearing of the application for approval of a surrogate motherhood arrangement, the court should be required to assess the suitability of the prospective parents for participation in such an arrangement.

38. Before the court approves a surrogate motherhood arrangement, the prospective parents should be required to satisfy the court that there is a

---

* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, dissents from this recommendation: see Vice Chairman's Dissent, at page 287 of this Report.

medical need that is not amenable to alleviation by other available means, including the artificial conception technologies.

* 39. The availability of surrogate motherhood to prospective parents should not be restricted on an *a priori* basis, but should depend on an assessment of the prospective parents by the court according to legislated standards. The court should be required to be satisfied that the intended child will be provided with an adequate upbringing; in making this determination, the court should be required to consider all relevant factors, including the marital status of the prospective parents, the stability of their union, and their individual stability.

40. Where a donated gamete is to be used in a surrogate motherhood arrangement from a donor who is neither the prospective surrogate mother nor a prospective social parent of the intended child, the treatment of the donor should be governed by the previously recommended provisions concerning gamete donors.

* 41. There should be no restriction on the eligibility of women to serve as surrogate mothers, so long as they have reached the age of majority at the date of the application for court approval of their participation in a surrogate motherhood arrangement.

42. On the hearing of the application for approval of a surrogate motherhood arrangement, the court should be required to assess the suitability of the prospective surrogate mother.

43. In assessing the suitability of a prospective surrogate mother, the court should consider, among other factors, her physical and mental health, her marital and domestic circumstances, the opinion of her spouse or partner, if any, and the likely effects of her participation in a surrogate motherhood arrangement upon existing children under her care.

44. The question of the standard of proof for approval of surrogate motherhood arrangements should be left to the courts responsible for determining the matter.

45. The surrogate mother should be a co-applicant in proceedings to approve a surrogate motherhood arrangement, but should not be required to be in attendance at the hearing of the application in every case. The surrogate mother should receive separate legal representation.

46. In order to minimize uncertainty concerning a child's parentage upon birth, the court should require that information relating to the blood type and other relevant biological characteristics of the surrogate mother, her husband or partner, if any, and the persons who produced the gametes involved should be placed before it prior to approval of the surrogate motherhood arrangement.

---

* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, disagrees with this recommendation: see *supra*, ch. 6, note 345.

* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, disagrees with this recommendation: see *supra*, ch. 6, note 350.

47. Notice of an application to the court for approval of a surrogate motherhood arrangement should be served upon the appropriate children's aid society, and the society should have standing to attend at the hearing of the application. However, a children's aid society should intervene only where its records disclose information demonstrating the unsuitability of either the surrogate mother or the prospective social parents for participation in the surrogate motherhood arrangement.

48. The anonymity of the prospective social parents and the surrogate mother and the confidentiality of court records pertaining to surrogate motherhood proceedings should be preserved. The application should be heard and determined *in camera*, the court records should be sealed, and access to the records should be granted only upon judicial approval for good reason.

49. A child born pursuant to an approved surrogate motherhood arrangement should be surrendered immediately upon birth to the social parents. Where a surrogate mother refuses to transfer the child, the court should order that the child be delivered to the social parents. In addition, where the court is satisfied that the surrogate mother intends to refuse to surrender the child upon birth, it should be empowered, prior to the birth of the child, to make an order for transfer of custody upon birth.

50. Where, following approval of a surrogate motherhood arrangement, there has been a change in circumstances, or new information has become available, indicating that the approved social parents are unsuitable to receive the child, the surrogate mother or the children's aid society should be permitted to apply, at any time prior to the date of the birth of the child, for a review of the approval of the surrogate motherhood arrangement, and the judge should be empowered to rescind the agreement.

* 51. Legislation should provide that no payment may be made in relation to a surrogate motherhood arrangement without the prior approval of the court.

52. In light of Recommendation 56, to the effect that, upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents will be the parents of the child for all legal purposes, legislation should not require that surrogate motherhood agreements contain special provisions dealing with legal responsibility for a handicapped child that is born pursuant to a surrogate motherhood agreement.

53. The court should be required to ensure that a surrogate motherhood agreement contains adequate provision dealing with the allocation of the power of decision relating to the medical care of a newborn handicapped child, and with the nature of that decision.

54. The matter of spontaneous abortion during a surrogate pregnancy should be left to agreement between the parties, as should the possibility that conditions may arise that justify a therapeutic abortion in accordance with the *Criminal Code*.

55. (1) The parties to a surrogate motherhood agreement should be free to

---

* Dr. H. Allan Leal, O.C., Q.C., Vice Chairman of the Commission, disagrees in part with this recommendation: see *supra*, ch. 6, note 381.

include in the agreement terms of their choosing; however, they should be required to consider, and to agree upon a resolution of, the following issues:

(a) health and life insurance protection for the prospective surrogate mother;

(b) arrangements for the child should the intended social father or mother, or both, die before the birth of the child;

(c) arrangements for the child should the intended social parents cease to live together as a couple;

(d) circumstances regarding the particular manner in which immediate surrender of the child to the social parents is to be effected;

(e) the right, if any, of the surrogate mother to obtain information respecting, or to have contact with, the child after surrender;

(f) prenatal restrictions upon the surrogate mother's activities before and after conception, including dietary obligations; and

(g) conditions under which prenatal screening of the child may be justified or required, for example, by ultrasound, fetoscopy or amniocentesis.

(2) Provided that the parties have considered each issue, they need not be required by the court to include in the agreement a term relating to that issue.

56. Upon the birth of a child pursuant to an approved surrogate motherhood arrangement, the social parents should be recognized as the parents of the child for all legal purposes, and the surrogate mother should have no legal relationship to the child.

57. Where a child is born prematurely, after an application by the surrogate mother or the children's aid society to review the surrogate motherhood arrangement (see Recommendation 50), but before the court has determined the matter, the court should have the power to make an order that the social parents are not to be recognized in law as the parents of the child.

58. The birth of a child pursuant to an approved surrogate motherhood arrangement should be registered under the *Vital Statistics Act*, showing the social parents as the mother and father. The surrogate mother should not be named in the register of births; nor should the fact that the child has been born to a surrogate mother appear in the register.

59. Children born pursuant to an approved surrogate motherhood arrangement should acquire inheritance rights through the approved parents. The child should have no inheritance rights against the estate of the surrogate mother simply by virtue of the biological relationship.

60. The Ministry of Community and Social Services should be required to regulate any agencies that arrange surrogate motherhood agreements.

61. Where a woman undergoes *in vivo* fertilization of an ovum intended for donation and becomes pregnant, she and the intended social parents should be able to apply to the court for approval of a surrogate motherhood arrangement in accordance with our previous recommendations. In approving the arrangement, the court should be empowered to determine unresolved terms of the agreement where all parties have approved the terms in principle, but have been unable to settle the details thereof by the time that the application for approval is presented.

62. Where an approved surrogate mother who is the intended recipient of a fertilized ovum becomes unavailable, there should be a summary procedure for the approval of a replacement surrogate mother where this is necessary to secure transfer of the fertilized ovum in order to avoid its wastage.

63. For the initial period during which surrogate motherhood agreements are regulated by statute, no specific provision should be enacted to address the question of such agreements made outside Ontario and intended for implementation in the Province.

64. No legislation need be enacted concerning the maintenance of medical records specifically in the context of surrogate motherhood. Rather, the previous recommendations dealing with medical records relating to the provision of artificial conception services should apply (see Recommendation 22).

65. A penalty of a fine should be provided for participation in a surrogate motherhood arrangement where it is known or believed that the arrangement is intended to evade the proposed regulatory scheme. However, where a professional whose assistance is sought is confronted with a *fait accompli* — for example, where an obstetrician is asked to deliver a pregnant surrogate mother's baby — he or she should not be subject to the proposed penalty for giving such assistance.

66. (1) Social parents who acquire custody of children born pursuant to unapproved surrogate motherhood arrangements should be allowed to utilize existing procedures, as modified by paragraph (2), to establish their parentage in law after the fact.

    (2) Where social parents seek an adoption order in relation to a child who is born pursuant to an unapproved surrogate motherhood arrangement and transferred to them, notice of the application should be served upon the appropriate children's aid society. Upon receipt of the notice, the children's aid society should be required to conduct a homestudy and submit to the court a report in relation thereto.

FURTHER REVIEW

67. Five years after the recommended regulatory regime has been implemented in whole or in part, a review of all aspects of the regime should be undertaken by an appropriate governmental body.

VICE CHAIRMAN'S DISSENT

We live in a world of impressive and burgeoning technological change. As an institution responsible for advising on the means for acceptable social ordering through law, we are deeply conscious of the necessity of formulating policy with these terms of reference in mind. We would ignore them at our peril. That is not to say, however, that all developments of high technology carry with them their own categorical imperative. In the realm of the physical sciences, the decision to manufacture and use the atomic bomb was not inevitable simply because the technology was available. The decision transformed the course of world events to the detriment of all mankind — friend and foe alike! It will not be easy, as we have experienced, to reverse this process, but it is vital that it be done since human survival depends upon it.

Likewise, in the realm of the health and related sciences, we are on the threshold of unlocking the mysteries of life itself. Many of the developments in medical science are applauded and welcomed because they, self-evidently, promote the betterment of the human condition. Others can be accepted with the controls necessary to ensure this result. Still others may have to be rejected, at least for our time, to accommodate our perception of an acceptable, just and workable society. I believe firmly that we can be the masters of our own destiny, both individually and collectively. At each fork in the path of our restless striving to build a better world and more civilized society, there are critical choices to be made. With an evolving sense of justice, may we have the abundant wisdom and courage to address these issues and make these value judgments in the best interests of our wider human society.

The directed study by this Commission of Human Artificial Reproduction and Related Matters has been an extremely burdensome and anxious task involving, as it must, many fundamental moral, ethical, social and legal issues. Not surprisingly, in this context, the nature of firmly held convictions on many major issues has led to a division of views. It is a matter of great personal regret to me that I must record my dissenting view with respect to two critical issues decided by my colleagues.

The first involves the status of those who would be eligible to apply for state subsidized medical assistance through the utilization of the artificial reproduction technologies. The second issue is whether surrogate motherhood should be permitted and, if so, what legal regime should be fashioned to accommodate it.

On the first issue, my colleagues have recommended that stable single women, and stable men and women in a stable marital or non-marital union, should be eligible to participate in an artificial conception programme. I would restrict eligibility for participation in this type of programme to couples in a stable marital union. In doing so, I am not unmindful of, nor indifferent to, the perceived hardship such a prescription might visit upon those who either do not wish to marry or are not free to marry. My reasons are pragmatic, in a sense, but they do involve a consideration of the best interests of parents and children alike. Our existing legal regime governing the family relations is predicated upon the fact that the procreation and rearing of children should take place within a marital union. It is admitted that there are exceptions made for the legitimacy of children born outside marriage and the imposition of mutual support obligations for partners, in certain circumstances, in non-marital unions, but these exceptions are morally defensible and necessary. In my view, they also serve to reaffirm the existence of the basic principle of our social ordering to which I have alluded.

Recently, a judge in British Columbia was asked to entertain an application for the enforcement of a support obligation in favour of one party in a lesbian union who had been artificially inseminated and had given birth to a child. The other party had consented and encouraged resort to these procedures in order that they might live as a "family", but she later withdrew from the union. The court, in dismissing the application, held that the legal prescriptions relevant to the family relations did not countenance this type of union and, accordingly, the remedy sought was not available. I do not pause here to contemplate whether one day this may all be changed and that marriage, as we know it, may cease to be the societal imperative that it is today. If and when that day arrives, I anticipate that the whole fabric of the law will have to be refashioned to accommodate this change in its basic premise. To accept and encourage resort to the artificial reproduction technologies by persons outside a stable marital union under the existing legal regime, in my view, is to sow the seeds of injustice, hardship, and social disorder and I would oppose it.

The issue whether or not to permit surrogacy within Ontario is more complex and equally troublesome. I remind myself that this issue was the immediate cause for the Reference having been made to this Commission by the Attorney General although, admittedly, the terms of reference were framed more broadly. The majority of my colleagues on the Commission, after the most anxious consideration, have decided to recommend that surrogacy be permitted and have also recommended the enactment of an elaborate legal regime within which surrogacy would be recognized and administered.

Again, I regret having to record my dissent from the basic decision to permit surrogacy, but have no reservation whatever in saying that if it is to be permitted, then all the legislative controls recommended by my colleagues are essential in order to attempt to contain the practice within acceptable societal norms and to minimize its potential for injurious social results.

I am encouraged in my opposition to the basic principle of permitting surrogacy by the knowledge that this view is shared in the reports of multidisciplinary groups studying this specific issue in the United Kingdom and Australia.[1] It is also apparent that a substantial body of public opinion in the

---

[1] Indeed, in Victoria, the recently enacted *Infertility (Medical Procedures) Act* 1984, No. 10163, provides *inter alia*, that a person shall not "make, give or receive, or agree to make, give or receive, a payment or reward for or in consideration of the making of a contract, agreement or arrangement under which a woman agrees to act as a surrogate

United States also favours this view. This is reflected in the fact that a number of state legislatures are contemplating prohibitory legislation. It should be added that my views crystallized even before the appearance of the reports referred to and, in that sense, were arrived at quite independently. Understandably, however, in rationalizing and formulating my reasons for decision, I have drawn heavily upon what others have thought and written.

Perhaps it is unnecessary to say that I am very much aware that for an uncertain, but I suspect a small number, of married couples, surrogacy may exist as a remedial practice of last resort. In taking a position that would deny this relief to them, I trust I will not be viewed as lacking in compassionate feeling. Essentially, the issue involves a critical balancing of societal interests and, in my view, the scales are tipped substantially and irreversibly in favour of a legal and social rejection of the practice.

The fundamental objection to the practice of surrogacy is its potential for exploitation. In an American study involving 125 women who had applied to act as surrogate mothers, it was found that in nearly every case a substantial fee was an essential precondition for participation in a surrogate arrangement.[2] In the only Ontario case which has been litigated, it was alleged that a fee of $10,000 was agreed to be paid to the surrogate. It is not suggested that a fee of this magnitude is exorbitant having in mind medical expenses, fees for psychological screening and counselling of the surrogate during and after pregnancy, living allowance for the surrogate during pregnancy, possible loss of salary or wages during pregnancy, etc. Added to these costs is that of a substantial fee usually payable to the surrogacy agency through which the arrangement was negotiated.

The reality of the practice is that surrogate mothers conceive and give birth to children with the intention of handing them over to someone else. This is usually done for a fee. The concept is totally foreign to a legal system such as ours in which we have sought to diminish exploitation of women and children by proscribing payment in the adoption process. The analogue may not be complete but it is close enough to be perilously relevant. It is also interesting to observe the growing support, in the search for control of prostitution, for the creation of criminal offences involving the male client. Surely this is a defensible means of achieving more effective control of a practice which is also basically exploitive.

My colleagues have striven valiantly to deal with the issue of payments and would limit the nature and quantum of the payment to that approved by the court. I am not sanguine about the enforceability of these strictures in a context where both parties to a surrogacy agreement are prepared to have funds change hands outside the agreement. Unhappily, collusive agreements are neither novel nor

---

mother" (s. 30(2)(b)) or "receive or agree to receive a payment or reward or consideration for acting, or agreeing to act, as a surrogate mother" (s. 30(2)(c)). It further provides that "[a] contract or agreement (whether made before or after the commencement of this section) under which a woman agrees with another person or other persons to act as a surrogate mother is void" (s. 30(3)).

[2] See Parker, "Motivation of Surrogate Mothers: Initial Findings" (1983), 140 Am. J. Psychiatry 170.

infrequent where the desires of the parties coincide in the pursuit of an unlawful purpose.

In dwelling upon the issue of the payment of a fee, I do not suggest that all actual or potential surrogates are prompted by strictly mercenary motives. Indeed, during the course of our study, I have been privileged to hear a panel presentation by an American surrogate and her husband involving an arrangement where no fee, presumably apart from medical expenses, was involved. One was greatly impressed by the sincere altruism which motivated this couple in their concern for others less fortunate than they. However, in the unfolding of this moving human drama, there was a terminal jarring note. In answer to a direct question of why she did it, the surrogate responded that she had done it to help her male superior at the office. Again, I am persuaded that in this particular case, there was no improper motive even in these circumstances. One need not be a total cynic, however, to see the fatal flaw in this arrangement. Quite obviously, surrogate agreements have the potential for exploitation, even in circumstances where direct payments are not being made.

On another point, in the instant case, the husband of the surrogate had had a vasectomy but the presentation also disclosed that following her artificial insemination by the genetic father, the husband of the surrogate thought it advisable to check the effectiveness of those operative procedures. Presumably this precaution was directed to the possibility of her retention of the child in the event that her husband was found to be the father of the child. This, of course, raises another source of conflict and difficulty with respect to surrogacy. Although the experience with surrogacy to date is relatively limited, there are already a number of significant cases where things have actually gone awry and one does not have to rely entirely on scenarios which are the product of a fertile imagination. At least one American case has already been litigated on the issue of proper identification of the father of the surrogate child. Surrogate agreements would normally involve an undertaking of abstinence from spousal sexual relations during the relevant periods of surrogate conception. In this case, the child born to the surrogate mother was abnormal and the purported genetic father disclaimed paternity. The court so found.

Surely there are few issues in human social and legal experience so fraught with difficulty and anxiety as that of compulsory surrender of a young child by its mother. Solomonesque judgments are superficially attractive in the abstract, but in real life they are simply not permissible.

There are other areas of concern involving the conduct of the surrogate mother which are quite beyond the power of the court and the contract to control adequately. Common prudence would dictate that the surrogate agreement would deal specifically with the obligation of the surrogate to take proper prenatal care. This human instinct is compelling during gestation of one's own child, although it may often be disregarded through ignorance. The contractual obligation arising from the surrogacy agreement may not be nearly so compelling and the possibility of its breach surely cannot be said to be in the best interests of the child in any way. The absence of any assurance that it will be observed in natural reproduction is no justification for accepting the risk in cases of artificial reproduction through surrogacy.

Because many of the concerns arising from artificial reproduction through surrogacy cannot be quantified, at least with our present limited experience, it does not mean that we are justified in ignoring them. In this category, we would place the avowed concerns involving the psychological effects on existing children of the surrogate mother when confronted with the fact that their mother is having a child which is to be given away at birth. Is such a situation conducive to their best interests?

Likewise, we are aware of the shifting sands of opinion, expert and otherwise, concerning the desirability and effects of disclosure to the child of information of the circumstances of its birth. We have been wrestling with this problem in the area of adoption for quite some time now and, unhappily, we do not seem to be any closer to an acceptable solution. Surrogate birth simply exacerbates that difficult human problem. When viewed in the abstract, the solution may seem relatively easy. Its application in individual cases is always difficult, troublesome and unsatisfactory. In this connection, one may well question the futility of the exercise of the young lady in California who is pledged to devote her lifetime and all her resources to establishing the identity of her genetic father. She was prompted to do so because she learned that her mother had been artificially inseminated by a semen donor. The practice at the time of her birth was to rely heavily on medical student donors as a source of human gamete material, but her desire to know is not otherwise based on medical reasons. Although it is reported that she has narrowed the field substantially, one suspects that her goal is proving to be frustratingly elusive and the task of identifying and locating gamete genetic siblings has not yet begun.

It would be tedious for the reader of this Report for me to attempt to recanvass all the issues of surrogacy which have been dealt with in the substantial chapter devoted to it. I have attempted to visit in this dissent the most obvious obstacles to the acceptance of surrogacy as an alternative means of childbearing. I have considered very carefully the responses of my colleagues and the statutory scheme which they recommend for eliminating them. I regret that I am not persuaded to their point of view. Like the Report of the Warnock Committee in the United Kingdom, I would reject the practice of surrogacy, recommend that surrogacy agencies be prohibited, recommend that the present law with respect to the non-enforceability of surrogate agreements on the ground of public policy be retained, and recommend that a provincial offence be created with respect to any professional assisting in the establishing of a surrogate pregnancy. I am conscious, of course, of the fact that couples may seek to fulfill their desires in this respect by going outside the jurisdiction, but there would appear to be little that one can do about this within the limits of the constitutional competence of the provincial legislature.

CONCLUSION AND ACKNOWLEDGMENTS

1. CONCLUSION

In the course of this Report, we have considered many difficult and controversial issues concerning human artificial reproduction. As we have observed, there is no community consensus with respect to the resolution of some of these issues, but rather divergent, and indeed often conflicting, positions. Whether these differences simply reflect the extremely intimate, sensitive nature of the subject or, more profoundly, particular philosophical or moral views, matters little. What is important is that there clearly are differing perceptions in the community, which no doubt will contribute to a vigorous debate after this Report has been published.

In anticipation of continuing controversy about many of the issues, it is important to emphasize that our task in this Reference has been not only to fashion solutions to legal problems, but also to construct a sturdy foundation of analysis and information for the public debate that is sure to follow.

2. ACKNOWLEDGMENTS

For their assistance in this task, we wish to express our sincere appreciation, once again, to Professor Bernard M. Dickens, of the Faculty of Law, University of Toronto, the Consultant to the Project, to the members of our Advisory Board, and to the artificial insemination and *in vitro* fertilization specialists who met with representatives of the Commission. The Commission benefited from their learned guidance during the course of this Reference.

We wish also to express our gratitude to Mr. M.A. Springman, Senior Legal Research Officer, and Mr. Larry M. Fox, Legal Research Officer, for their scholarship and dedication in the writing of this Report and in bringing this

Project to a successful conclusion, and to Ms. M. Patricia Richardson, Counsel to the Commission, for her invaluable assistance in the preparation of this Report.

All of which is respectfully submitted,

James R. Breithaupt
Chairman

Allan Leal
H. Allan Leal
Vice Chairman

Richard A. Bell
Commissioner

William R. Poole
Commissioner

Barry A. Percival
Commissioner

March 15, 1985

APPENDIX

REFORM AND PROPOSALS FOR REFORM IN OTHER JURISDICTIONS

1. INTRODUCTION

As we have indicated in chapter 5, during the past several years there has been an increasingly avid interest in human artificial reproduction. In addition to a burgeoning literature, legislation and regulatory guidelines have been adopted or proposed in respect of the new technologies.

The material reviewed in this Appendix canvasses the medical, legal, ethical, social, and other issues addressed by reports, legislation, and guidelines from jurisdictions outside Ontario. While we cannot be exhaustive in our review, the material selected represents a broad cross-section of the ways in which informed bodies and legislatures have attempted to deal with the problems generated by the new artificial conception technologies.

2. RESEARCH AND REPORTS

(a) CANADA

(i) British Columbia, Royal Commission on Family and Children's Law

In 1975, with the guidance of a multidisciplinary Working Group, the British Columbia Royal Commission on Family and Children's Law published a Report on artificial insemination.[1] The Commission's main concern was "to safeguard the interests of all the parties involved" by means of "some protective regulation".[2] It did not "[attempt] to judge whether this procedure should be encouraged or discouraged".[3]

---

[1] British Columbia, Royal Commission on Family and Children's Law, *Ninth Report of the Royal Commission on Family and Children's Law: Artificial Insemination* (1975) (hereinafter referred to as "British Columbia Royal Commission Report").

[2] *Ibid.*, at 2.

[3] *Ibid.*

The Commission, after cataloguing several situations where legal liability might result from A.I.D.,[4] concluded "that when a child is conceived through AID within marriage, all the legal protections of the marital relationship should be automatically in force".[5] The Commission then continued with a wide-ranging recommendation dealing, *inter alia*, with the need for written consents from the recipient and her spouse, full disclosure, and the absolving of the doctor from liability where he has "carried out a standard level of care".[6] It stated that, where the husband consents to the insemination, and whether the sperm is that of the husband or a donor, the child should have the same legal standing as a child conceived naturally with the husband's sperm. Accordingly, the husband would have responsibility to support the child and the child would have full rights of inheritance. Moreover, the "donor should remain anonymous and should not be held liable for support of the child, nor should he be allowed to claim access or other rights to the child".[7]

The Commission next turned to the "ethical issues" involved in A.I.D. Emphasis was placed on the need to protect certain "human values" as well as the interests of society and those involved in the procedure, while not resisting beneficial technological innovations.[8] In this context, it considered eligibility for participation in A.I.D. The Report assumed, without explanation, that some screening of prospective recipients by physicians was necessary, although it did discuss the standards applicable to such selection.

The Commission began with the assertion that "[i]n principle, rules as to eligibility for AID should be the same as for adoption".[9] In view of the importance of the Commission's assumption that the ability to become a "successful" parent was critical in evaluating a potential A.I.D. recipient, the full discussion is reproduced here:[10]

---

[4] *Ibid.*, at 3-5. The Commission stated that some of its concerns would be removed by implementing other Commission proposals respecting the abolition of illegitimacy: see British Columbia, *Fifth Report of the Royal Commission on Family and Children's Law*, Part II, *The Status of Children Born to Unmarried Parents* (1975).

[5] British Columbia Royal Commission Report, *supra*, note 1, at 5.

[6] *Ibid.* Although the Commission believed that, "[i]n terms of AID, the physician at present will probably be held liable only if he fails to exercise reasonable care during the insemination procedure or in the selection of a donor or sperm bank" (*ibid.*, at 21), it expressed some concern that strict liability might be imposed. The Commission's proposal was as follows (*ibid.*, at 25, recommendation 15 (emphasis in original)):

> A new statute should impose a negligence standard on the doctor, and expressly exclude any concepts of implied warranties. However, if the doctor's consent form and counselling did not include a *full disclosure* of the risks involved, this omission should be seen as constituting negligence *per se* in the event of any problems caused by the procedure which are experienced by the baby or the recipient.

[7] *Ibid.*, at 6, recommendation 1.

[8] See *ibid.*, at 9, recommendation 2.

[9] *Ibid.*, at 10.

[10] *Ibid.*, at 10-11. See, also, recommendation 3, *ibid.*, at 11.

> Who, then, should be eligible for AID? One approach to a decision might be the development of a test of 'ability to nurture', which would involve guidelines describing generally the types of emotional and social variables which seem essential to success in parenting a child. The potential recipient would be evaluated on her ability to meet these guidelines and would not be eliminated from consideration just because of her marital status. This 'ability to nurture' test would include the concepts of guidance and a stable home environment as well as the recipient's ability to provide for the child's needs. In our Report on Children's Rights, we suggested that the child's needs can be expressed as a legislative standard. The mother's ability to meet this statement of Children's Rights (see Appendix II) should be the main criterion as to her ability to nurture a child.
>
> The guidelines, moreover, would also involve an evaluation of the physical and mental health of the potential recipient. It is suggested that an attempt to judge the recipient in terms of her conformity to prevailing mores about marriage and lifestyle should be made in the context of their current state of flux and, more importantly, should concentrate on the conduct of the individual which can be shown to relate quite directly to her ability to nurture. As suggested above, the central concern in evaluating the prospective AID recipient should focus directly (and singularly) on her ability to be a successful parent. It is the potential child's interest which must be paramount in this situation.[11]

Notwithstanding, then, that the guidelines would require an evaluation of more than simply the health of the applicant, the Commission recommended that a physician ultimately should use his own professional judgment, on the basis of certain guidelines, to decide whether to accept or refuse a candidate.[12]

With respect to the selection of donors, the Commission offered recommendations designed "to avoid the embarrassment of unintended exposure of the child's origin".[13] For example, except where medically undesirable, "the selection of the prospective donor should allow as far as possible for inheritance of blood characteristics compatible with paternity by the child's presumed father".[14] The desire to preserve the anonymity of the donor was reflected in the further proposal that "[t]he donor and recipient family should remain unidentified to each other" and that "the donor should commit himself to refrain from seeking out the recipient family or the child".[15] Moreover, "[n]either the donor, nor a child conceived by artificial insemination, should have any claim over the other, such as inheritance rights".[16]

---

[11] With respect to eligibility, the Commission later recommended that "[a] set of guidelines should be developed by which a physician may apply medical and social criteria in deciding whether to provide artificial insemination for an applicant requesting it": *ibid.*, at 20, recommendation 14.

[12] *Ibid.*, at 11, recommendation 4. The Commission further stated that "an individual physician has the right to refuse a request for AID": *ibid.*, at 12. The Commission rejected the notion that the physician should be required to have "the backing of a number of colleagues acting as a tribunal", since "sheer numbers in such a body might jeopardize the confidentiality of the situation": *ibid.*, at 11.

In this connection, reference should be made to the recommendation that a rejected A.I.D. applicant should be entitled to appeal to a specially constituted tribunal "representative of medicine, social sciences and appropriate agencies of government": *ibid.*, at 12, recommendation 5.

[13] *Ibid.*, at 14, recommendation 8.

[14] *Ibid.*

The psychological and other effects of donation on a donor and his family were also considered in the Report. In addition to the provision of "special counselling", it was proposed that "[t]he donor's signed consent should absolve the physician and the recipient of any liability in the event that there is an allegation that adverse psychological effects have been produced by the procedure".[17] It should be noted that the Report did not suggest that the spouses of donors must give their consent prior to donation.

The Commission then turned to general medical considerations, particularly the "medical, biological, or genetic documentation of the donor". Ordinarily, such documentation would not be of much interest[18] and, therefore, ought to be confidential. Moreover, the Commission had recommended generally that "[t]he child should not have the fact of his origin by artificial insemination divulged to him".[19] However, as an exception, the Report recommended that "[s]ome system should be devised, without susceptibility to breach of confidentiality, whereby appropriate investigation and counselling may be launched if a genetically determined disease should become manifest in the donor or the child conceived by artificial insemination, following the procedure, if in the opinion of a geneticist or genetic counsellor this information may be important to the reproductive planning by the person concerned".[20]

To help avoid the transmission of disease by diseased sperm donors who may be anxious to make a profit from repeated donations, the Commission recommended that "a limit should be placed upon the numbers of successful sperm donations that may be provided by any individual donor. An arbitrary number might be six".[21] In addition, a donor "should receive full and adequate recompense for his time, expenses and the loss of any revenue that he may sustain in making himself available for sperm donations, sufficient to enlist his cooperation"; however, "it would seem inadvisable to pay him a price for the seminal fluid itself".[22]

Concerning the effect of A.I.D. on the registration of births, the Commission expressed the view that "[n]o significant reasons have been advanced for suggesting that the fact of AID should appear on, or be ascertainable from, the registration of birth or any related records in the Division of Vital Statistics".[23] Again, the principle of confidentiality was emphasized.

---

[15] *Ibid.*, at 15, recommendation 9.

[16] *Ibid.*, at 19, recommendation 13.

[17] *Ibid.*, at 16, recommendation 10.

[18] *Ibid.*, at 18.

[19] *Ibid.*, at 14, recommendation 7.

[20] *Ibid.*, at 27, recommendation 16.

[21] *Ibid.*, at 19, recommendation 12.

[22] *Ibid.*, at 23.

It was noted that, while a married woman living with her husband must register "the particulars of the husband as those of the father of the child", the physician's duty to submit a notice of birth, with the name of the father,[24] may make him reluctant to record the husband as being the father where he is aware of the use of A.I.D. In order to ensure the secrecy of the fact of A.I.D., the Commission recommended that the physician be required to "enter on the notice the name of the husband of the mother as being the name of the father".[25]

The Commission then turned to the accessibility of "confidential information relating to research, quality control of AID services, and, in some instances, to the future health and genetic interests of an individual".[26] The Commission recommended that such information "should be stored for restricted retrieval in the physician's confidential files".[27] The only exception made was in the case of confidential information collected by fertility clinics[28] attached to sperm banks.[29]

The last section of the Report dealt in more detail with sperm banking. The Commission expressed its view that, given "the many unanswered questions"[30] with respect to collection, storage, documentation, and confidentiality, and given the need for further research concerning sperm storage, "a sperm storage facility should be restricted to an institutional base in which there is accountability, both to society through the government,[31] and to the most critical academic and professional authorities, through a university based sponsorship or joint sponsorship".[32] The "institutional base" should "preferably [be] connected with a research and service component relating to problems of human infertility".[33] To minimize problems, "[p]rivate or commercial sperm banks should not be recommended unless their facilities and services are subjected to close governmental surveillance".[34]

---

[23] *Ibid.*, at 27.

[24] See, now, *Vital Statistics Act*, R.S.B.C. 1979, c. 425, ss. 2 and 3(6)(b).

[25] British Columbia Royal Commission Report, *supra*, note 1, at 29, recommendation 17.

[26] *Ibid.*, at 30.

[27] *Ibid.*, at 31, recommendation 18.

[28] *Ibid.*

[29] *Ibid.*, at 30. The Commission stated that, with respect to information stored in sperm banks, "[p]olicies relating to content, confidentiality, retrievability, and authorization for access could be established to serve the interests of society and the individual" (*ibid.*).

[30] *Ibid.*, at 32.

[31] The Commission recommended (*ibid.*, at 33, recommendation 21):

> The Health Protection Branch, Health and Welfare, Canada, should be requested to take on responsibility for surveillance of human sperm banking, with associated collection, processing, distribution and documentation services. Appropriate federal legislation to provide this mandate should be proposed.

See *infra*, sec. 2(a)(iii).

[32] *Ibid.*, at 32. See, also, *ibid.*, recommendation 19.

(ii) Alberta, Institute of Law Research and Reform

In 1976, the Alberta Institute of Law Research and Reform published its Report on the *Status of Children.*[35] Chapter XII dealt solely with the question of legitimacy in the context of artificial insemination.[36] The Institute's recommendations were as follows:[37]

> (1) That if a married woman is artificially inseminated with semen all or part of which is donated by a man other than her husband
>
> (i) the donor not be in law the father of the child, and
>
> (ii) the husband be in law the father of the child if he consents to the artificial insemination but not otherwise.
>
> (2) That subsection (1) apply with necessary changes to a woman and a man who without being married cohabit throughout the year preceding the child's birth, but only if the man also consents to assume the responsibilities of parenthood.

The Institute stated that it is "far from clear" that the child's best interests would be advanced by legally obliging a nonconsenting husband to take responsibility for the child, given that his lack of consent evinces an unwillingness to do so.[38]

(iii) Health and Welfare Canada, Advisory Committee on the Storage and Utilization of Human Sperm

In 1981, the federal Advisory Committee on the Storage and Utilization of Human Sperm submitted its Report.[39] Emphasizing the need for provincial legislation,[40] the Committee warned that continuing uncertainty in the law and the "legal risks to donors and physicians"[41] may well lead to a considerable restriction of the procedure and, perhaps, to an increased use of A.I.D. from "unregulated sources".[42]

---

[33] *Ibid.*, recommendation 19.

[34] *Ibid.*, recommendation 20.

[35] Alberta, Institute of Law Research and Reform, *Status of Children* (Report No. 20, 1976).

[36] "[W]e are not concerned in this Report with regulation of the practice of artificial insemination nor with its ethical, sociological, religious or psychological implications": *ibid.*, at 91.

[37] *Ibid.*, at 93. See, also, Draft Bill, s. 8.

[38] *Ibid.*, at 92.

[39] Canada, Health and Welfare Canada, *Report of the Advisory Committee on the Storage and Utilization of Human Sperm* (1981) (hereinafter referred to as "Health and Welfare Canada Report").

[40] *Ibid.*, Letter of Transmittal, at 1.

[41] *Ibid.*, at 31.

After noting that, in Canada, there were fewer A.I.D. births involving congenitally defective children than might have been expected in the same number of births in the general population,[43] and that emotional reactions that might harm the new family appear to be rare,[44] the Committee concluded that "AID is a socially acceptable and beneficial medical procedure".[45] However, the Committee was equally clear that "the bearing of a child by AID is neither a right which should be claimed by anyone nor an obligation which should be imposed upon anyone".[46]

Chapter I dealt with the issue of legitimacy.[47] To rectify the present unsatisfactory state of the law, the Committee recommended the enactment of legislation "extending the definition of legitimacy to include children born through AID to which the husband[48] of the mother has consented in writing".[49] Where such consent has been given, the name of the mother's husband would be entered as the name of the father.[50] Unfortunately, the Committee did not indicate why the status of the child ought to depend on written consent.

In chapter II of the Report, the Committee recommended that federal regulations should establish standards in respect of the acquisition, preservation, and importation of sperm.[51] In addition to recommending donor screening in order to ensure medical[52] and psychological suitability,[53] and donor interviews and counselling,[54] the Report discussed the potential problem of propagating genetically defective children on a large scale and of increasing the chances of "inadvertent consanguinity".[55] It proposed that "[d]onor selection procedures should ensure that a limit to the number of pregnancies from any one donor may be set up".[56]

---

[42] *Ibid.*

[43] *Ibid.*, at 12.

[44] *Ibid.*, at xi. See text accompanying notes 67-73, *infra*. With respect to the effect of A.I.D. on the marriage, the Committee concluded that, "in principle", A.I.D. need not involve "a violation of the exclusivity and totality characteristic of the structure of the marriage relationship": Health and Welfare Canada Report, *supra*, note 39, at 37. A.I.D., therefore, need not be morally rejected as a matter of principle.

[45] *Ibid.*, at xi.

[46] *Ibid.*, at xii.

[47] It is interesting to observe that, to buttress its view that A.I.D. children should be considered legitimate, the Committee stated categorically that, "[i]f parents wish to have a child by AID they must surely be prepared to accept that child as a full member of the family unit and to provide for his or her needs and protection": *ibid.*, at 2. See, also, *ibid.*, at 42: "There is explicit acceptance ... of [the couple's] joint responsibility for any children conceived through AID perhaps even more responsibility than is felt by many couples conceiving 'normally'."

[48] "The committee was not able in the time available to discuss the subject [of the use of A.I.D. for the fertilization of a woman without a 'male partner'] in sufficient depth to form recommendations": *ibid.*, at 46.

In chapter IV, the Committee listed several vital questions "that direct attention to some of the principal conditions which have to be considered in elaborating the ethics of AID": *ibid.*, at 38. For example, one set of questions related to whether the proposed recipients — a homosexual or unmarried couple or person — could give "a sufficient guarantee of stability": *ibid.*, at 38, para. 2.

[49] *Ibid.*, at 3, recommendation 1.1. See, also, *ibid.*, at 3, recommendation 1.2.

[50] *Ibid.*, at 4, recommendation 1.3.

The Committee was particularly concerned with the importation of sperm and the use of commercial sperm banks. It was of the view that, "[u]ntil regulations establishing federal standards of quality are in effect for Canada, the importation of sperm from commercial human sperm banks should be prohibited; and no new human sperm bank should be allowed to operate outside the jurisdiction of a university or other publicly owned agency".[57]

Chapter III of the Report dealt with guidelines for A.I.D. centres. Indeed, the Committee recommended that "AID be available only where guidelines are met to safeguard the interests of donor, recipient and progeny".[58] The guidelines would relate to record keeping, counselling, consents for A.I.D., insemination procedures, and "procedures to be followed if an infant is born with an abnormality".[59]

With respect to whether medical records should link donors and recipients, it was recognized that information concerning congenital defects attributable to a donor's sperm would be valuable to the donor. Yet, there was some concern that the general absence of confidentiality of medical records could prove prejudicial to donors. In addition, it was believed that "it may be impossible to obtain donors if they cannot be assured anonymity".[60]

---

[51] *Ibid.*, at 5.

[52] *Ibid.* See, also, *ibid.*, at xiv, recommendation 2.2. The Committee went into considerable detail with respect to the genetic criteria used to evaluate the donor (and his "first degree relatives"): see *ibid.*, at 7-9. See, also, *ibid.*, at 11-12.

[53] *Ibid.*, at 6. The Committee recommended that a psychological evaluation should be made of his wife, if the donor is married: *ibid.*

[54] *Ibid.* For example, the donor would be told of "the ethical and legal status of the AID program, record keeping, donor liability and technique of sperm acquisition".

[55] *Ibid.*, at 12.

[56] *Ibid.*, at xiv, recommendation 2.4. See the suggestions made *ibid.*, at 12.

[57] *Ibid.*, at 16 and xiv, recommendation 2.5. With respect to the use of frozen sperm from banks, see *ibid.*, at 29-30. For recent federal developments in this area, see *supra*, ch. 3, sec. 4(b).

[58] Health and Welfare Canada Report, *supra*, note 39, at 17.

[59] *Ibid.* With respect to the latter issue, see *ibid.*, at 30, where the Committee said that, if an abnormality indicates an appreciably increased risk in respect of the donor's children, "consideration should be given to the donor's right to be informed" of the facts. However, the Committee did not expressly endorse such a right.

[60] *Ibid.*, at 20.

On balance, while the Committee endorsed donor anonymity,[61] it advocated the keeping of "linkable records",[62] but only if provincial legislation were enacted to ensure the following:[63]

> 1) That no legal relationship exists between the donor and the child fathered by his sperm.
>
> 2) That the donor has no legal responsibility to anyone arising from the sperm donation if he has given full and accurate answers, to the best of his knowledge and belief, to the questions asked of him by the physician involved, concerning his genetic background and medical history.[64]
>
> 3) That the standard of care required by the physician is that of reasonable care and that the physician has no legal responsibility to the child beyond exercising that reasonable care in the obtaining of sperm and the insemination.

In part of chapter III, and in chapter V, the Committee dealt first with the need for comprehensive counselling[65] and clearly written consent forms[66] and then considered the effects of A.I.D. on the family. In the latter connection, the Committee stated, on the one hand, that, "[s]ince the social father accepts his role from the onset of pregnancy, the child is born in accord with the wishes and actions of both parents".[67] On the other hand, the Committee stressed that "[a]n immediate and long-term potential for good, and harm,[68] is present",[69] although the measurement of this potential would be exceedingly difficult. For example, there was said to be "no 'marital stability index' to apply to families and no objective techniques for assessing 'successful parents' or 'happy children' ".[70] However, the Committee stated that physicians' reports "are generally positive", and "[q]uestionnaire surveys of the family sometime after the baby arrives have also reported favourably on AID".[71] While stating that, "in truth, no one really knows",[72] the Committee concluded that "[t]he impression gained by the committee is that AID rarely harms and may often strengthen the family".[73]

---

[61] *Ibid.*, at 21.

[62] The Committee recommended as follows (*ibid.*, at 23):

> Thus, if linkable records related to AID are to be maintained, then for the protection of all parties, records should be kept long enough that for practical purposes most genetic defects would be manifest in the child. The committee recommends that records should be maintained which collect all relevant and available information on the donor. A separate record should document the history and the physical, laboratory and follow-up data on the couple and the progeny.

The Report also contained a proposal relating to the discovery and treatment of transmissible genetic defects. The Committee recommended that "routine pooling or mixing of sperm from different donors for artificial insemination should be avoided" (*ibid.*, at 29). The Committee believed, for example, that this procedure "effectively prevents any search for possible cause when a congenital malformation is discovered, or for the identification of patterns of inheritance when a hereditary disorder is discovered" (*ibid.*).

[63] *Ibid.*, at 21. See, also, *ibid.*, at 22. Anonymity "could be protected by the statutory establishment of a board with the object of inquiring into any legal claim arising from a genetic or congenital defect in an AID child" (*ibid.*). Where, for example, the donor wilfully gave incorrect information, his name "would be revealed to the parties [but] it would be protected by law from publication" (*ibid.*).

[64] The Committee recommended that "provincial legislation be passed to protect the donor from unfounded or frivolous legal action" (*ibid.*, at 25).

[65] *Ibid.*, at 26. For details, see *ibid.*, at 25-26.

[66] *Ibid.*, at 27. For details, see *ibid.* The information to be given to the couple would be wide-ranging, concerning, for example, the future relationship between the donor, recipient couple, and child.

[67] *Ibid.*, at 41. See, also, *supra*, note 47.

(iv) Law Reform Commission of Saskatchewan

In 1981, the Law Reform Commission of Saskatchewan published its *Tentative Proposals for a Human Artificial Insemination Act.*[74] The document dealt with pre-insemination issues and the legal position of physicians and others involved in or affected by the procedure. In addition, there was a draft *Human Artificial Insemination Act*, with commentary, appended to the Report.[75]

At the outset, the Report noted the general absence of any "background from which to draw guidance in dealing with" the social, legal, and medical issues connected with the use of artificial insemination.[76] Significantly, the Commission stated that "it is not particularly helpful to adopt conclusions based on analogy to other types of human relationships, legal structures or medical procedures".[77] For example, the fact that the state does not interfere with respect to "natural" procreation does not necessarily mean that no such intervention is reasonable where artificial insemination is contemplated. However, the Commission stated that the "legislation recommended in the report would, if enacted, involve no more intervention in the practice of artificial insemination than appears absolutely necessary to guarantee and protect the basic rights of persons involved".[78]

---

[68] Because, for example, the father may reject the child as not his own, or the mother may reject the husband by "excessive attachment to 'her' child", the child "may be more vulnerable at times of later family stress": Health and Welfare Canada Report, *supra*, note 39, at 43.

[69] *Ibid.*, at 41.

[70] *Ibid.*, at 41-42. These facts bear on recommendations in several other reports that, for example, prospective couples should be screened as to their suitability for parenthood.

[71] *Ibid.*, at 42.

[72] *Ibid.*

[73] *Ibid.*, at 44.

[74] Law Reform Commission of Saskatchewan, *Tentative Proposals for a Human Artificial Insemination Act* (1981) (hereinafter referred to as "Law Reform Commission of Saskatchewan Report").

[75] *Ibid.*, at (vi) *et seq.* (hereinafter referred to as "Draft Act").

[76] *Ibid.*, at 2.

[77] *Ibid.*

With respect to pre-insemination issues, the Report stated that one of the most important questions was whether A.I.D. should be restricted to married couples.[79] While the Commission noted the refusal of some physicians to inseminate single women,[80] it stated that such refusal might violate *The Saskatchewan Human Rights Code*.[81] The majority of the Commission recommended that "the social and economic criteria for selection of artificial insemination recipients should, for the time being at least, not be prescribed by law except to the extent that *The Saskatchewan Human Rights Code* now prohibits discrimination".[82] The Report concluded that "[t]he law is not the best vehicle for establishing guidelines for the determination as to who is a good parent and who is not".[83] The Commission stated that, where a married woman seeks artificial insemination, an "important social question ... is whether or not the consent of the recipient's husband should be a prerequisite".[84] A majority of the Commission recommended that "legislation should not specify that a husband's consent be required",[85] although, "as a matter of social policy", the Commission agreed that "physicians should be very reluctant to inseminate a married woman without her husband's consent".[86]

The Commission turned next to a consideration of donor selection, noting the "rather disturbing failure to investigate and screen donors adequately".[87]

---

[78] *Ibid.*, at 3. For a discussion in this Report of the state's role in the case of artificial conception, see *supra*, ch. 4.

[79] Law Reform Commission of Saskatchewan Report, *supra*, note 74, at 1-2.

[80] The reason advanced was that the physicians "are not satisfied that a child born into a single parent family will receive the same quality of upbringing and support as a child born to two parents" (*ibid.*).

[81] S.S. 1979, c. S-24.1.

[82] Law Reform Commission of Saskatchewan Report, *supra*, note 74, at 1-4.

[83] *Ibid.*

[84] *Ibid.*, at 1-3.

[85] *Ibid.*, at 1-4.

[86] *Ibid.* While the Commission stated that "[t]he decision as to whether or not to become pregnant is not one in which the law should play a role", and that "[t]he woman who bears a child should be free to make her own choice" (*ibid.*), it should be emphasized that, except insofar as the human rights legislation was involved, the Commission did not comment negatively on the role of the physician in selecting recipients for artificial insemination.

In his dissent, Mr. G.J.D. Taylor, Q.C., responded by saying that he did "not believe that questions of social policy should be left to individual doctors, any more than to individual lawyers" (*ibid.*, at 4-2). Rather, legislation should require the written consent of the husband living with his wife (*ibid.*, at 4-1 to 4-2). His dissent was based on his view that marriage is founded on "mutual trust and respect between spouses" (*ibid.*, at 4-3).

[87] *Ibid.*, at 1-8. The Report quoted extensively from Curie-Cohen *et al.*, "Current Practice

This latter fact prompted the Commission to recommend regulations respecting "minimum investigation and screening",[88] at least for the moment: "[o]nce the medical community comes to agreement concerning the minimum requirements, the regulations should be repealed".[89]

The Commission's concern for the health of the participants was reflected in a further proposal that artificial insemination should be carried out only by a licensed physician or by medical personnel acting under the direct control of a licensed physician.[90] However, the Commission did not indicate the nature of the sanction, if any, that should apply where artificial insemination is performed in violation of this injunction.

Turning to the legal position of physicians, the Commission first examined the bases for potential liability to a recipient. While the Commission concluded that the law of negligence and contract should be retained as the basis for setting legal obligations owed by physicians to recipients,[91] some areas were thought to be in need of express regulation. For example, the Commission was concerned with the role of exclusionary clauses in respect of contractual and tortious liability. The Commission stated that "waiver forms" and consent forms "serve a useful purpose and their use should not be prohibited".[92] However, it subsequently recommended that "[a]ny agreement, contractual term or waiver of liability which purports to exonerate a physician or any other person from liability for negligent acts or omissions in connection with artificial insemination or any express warranty or misrepresentation made by the physician or other person should have no legal effect".[93]

---

of Artificial Insemination by Donor in the United States" (1979), 300 New England J. Med. 585.

Notwithstanding the Commission's concern respecting the investigation and screening of donors, it stated that "a physician should not be required by law to refuse artificial insemination services after the woman in question has been apprised of the risk and has decided to proceed with the insemination" (Law Reform Commission of Saskatchewan Report, *supra*, note 74, at 1-11). The Commission concluded that, "[i]f the recipient is determined to be inseminated, it is better that the insemination be carried out under medically controlled conditions" (*ibid.*).

[88] The Report emphasized that, in some cases, additional investigation and screening may be necessary: *ibid.*, at 1-10 and 1-12 to 1-13, recommendation I(4). See, also, Draft Act, s. 4, and Comment (*ibid.*, at (xix)), and s. 25(a).

[89] *Ibid.*, at 1-9. See Draft Act, s. 4, and Comment (*ibid.*, at (xix)). The Commission recommended that "[l]egislation should not specify investigation and screening requirements directed toward ensuring that a donor is matched to a recipient or the husband of a recipient with respect to race, physical characteristics or intelligence" (*ibid.*, at 1-13, recommendation I(5)).

[90] *Ibid.*, at 1-12, recommendation I(3). See Draft Act, ss. 3 and 24.

[91] *Ibid.*, at 2-5, recommendation II(1). See Draft Act, s. 8.

[92] *Ibid.*, at 2-4.

[93] *Ibid.*, at 2-5, recommendation II(4). See Draft Act, s. 11. In chapter II, the Commission stated that *The Sale of Goods Act*, R.S.S. 1978, c. S-1, and *The Consumer Products Warranties Act*, R.S.S. 1978, c. C-30, probably did not apply to a contract between an

The Commission then turned to consider the physician's potential liability to a child born as a result of artificial insemination.[94] In the context of prenatal injury actions, the Commission concluded that "[a] physician practising AID would ... be liable to a child born with injuries suffered as a result of damage done to the child while *en ventre sa mere*, if those injuries resulted from his negligence".[95] However, the Report stated that "[a] much more difficult issue concerns the liability of a physician practising AID for damages arising out of the conception itself",[96] where the injuries arise "from the fact that negligence occurred prior to or during insemination".[97] In such a case, the Commission recommended as follows:[98]

> [The child should] be able to recover pecuniary and non-pecuniary damages for losses to which he has been subjected or will, in the future, be subjected, as a result of the fact that he was born with abnormalities which an AID child would not have if the negligence had not occurred. The claimant should be able to recover damages of the kind and in the amount recoverable by a person who initially did not suffer the abnormalities of the claimant, but who suffered abnormalities identical to those of the claimant as a result of the negligent acts or omissions of the defendant.[99]

A.I.D. physician and a recipient: Law Reform Commission of Saskatchewan Report, *supra*, note 74, at 2-3. However, to remove any doubt, the Commission recommended that these statutes should not apply to a contract between a physician or hospital and an A.I.D. recipient: *ibid.*, at 2-5, recommendation II(2). See Draft Act, s. 9.

The Commission also dealt with the applicability of any implied warranty of reasonable fitness, particularly where defects in the semen "could not have been discovered upon reasonable investigation and screening of the donor by an expert": *ibid.*, at 2-4 (footnote reference deleted). The Commission noted that the courts might well apply the warranty even though a contract for professional services was involved. Accordingly, the Commission recommended that "[t]here should not be implied in a contract of service between a physician practising artificial insemination and a recipient any implied warranties as to the semen used in the insemination": *ibid.*, at 2-5, recommendation II(3). See Draft Act, s. 10.

For analogous proposals that deal with the applicability of the implied warranties where a donor is paid for his semen, see *ibid.*, at 3-14 and 3-16, recommendation III(9). See, also, Draft Act, s. 10.

[94] It also discussed "wrongful life" actions, that is, those brought by a child — usually mentally or physically impaired — where it is alleged that, but for the wrongful act of the defendant, the child would not have been conceived or, if already conceived, would not have been born alive. However, "wrongful life" actions were not the subject of a specific proposal.

[95] *Ibid.*, at 2-8.

[96] *Ibid.*

[97] *Ibid.*

[98] *Ibid.*, at 2-16, recommendation III(6).

[99] The rationale for the last portion of this proposal was "to avoid the need to develop an entirely new body of damages law to deal with any perceived peculiarities arising in this context" (*ibid.*, at 2-14). "In other words", the Report explained, "even though an AID child is not in existence when the negligent acts or omissions which caused his injury

A further issue concerned "the physician's duty to report genetic defects later appearing in the donor to the child or the child's parents".[100] The Commission proposals appeared to recognize the difficulties in imposing a duty to inform children and parents of defects discovered after insemination. However, it also accepted the need to keep records:[101]

> Legislation should not be enacted to require a physician who has performed artificial insemination to inform children born as a result thereof, or their parents, of genetic defects in donors of the semen used, where such defects come to the attention of the physician after artificial insemination has been performed.
>
> All physicians practising artificial insemination and hospitals or other medical organizations which provide facilities for artificial insemination should keep such records of all instances of artificial insemination as are prescribed in regulations.[[102]]

The Commission next considered the statutory standards for civil liability of doctors, hospitals, or others to A.I.D. recipients, their husbands, and children. It first reemphasized its view that, "where possible, medical experts [should] formulate minimum standards of general application, and that generally, physicians in charge of the process of artificial insemination [should] ensure that the investigation and screening necessary in the circumstances is conducted".[103] The Commission then offered several proposals relating to the specific circumstances where a doctor or other person may be held liable.[104]

---

occurred, he should be able to recover damages of the kind and in the amount normally recovered by someone who is negligently injured" (*ibid.*). See Draft Act, s. 12.

[100] *Ibid.*, at 2-14.

[101] *Ibid.*, at 2-16, recommendations II(7) and (8). With respect to the proposed requirement to keep records, see Draft Act, ss. 6, 24, and 25(b).

[102] The Commission went on to say, however, that "requirements as to records should not force physicians to abandon the practice of inseminating with sperm from more than one donor per cycle" (*ibid.*, at 2-15), even though the Commission noted earlier that this practice is prompted to some extent by the wish of doctors "to ensure that ... tracing is, if not impossible, extremely difficult" (*ibid.*, at 2-14).

[103] *Ibid.*, at 2-17. With respect to proving negligence, the Report noted that "the injury may well have occurred even if the physician had not been negligent": *ibid.*, at 2-21. For example, a donor may conceal indications of transmissible genetic disorders. Since the identity of the donor is unknown to the plaintiff, the former cannot be called as a witness in any litigation to prove that he was, in fact, truthful in his responses to the physician's inquiries prior to donation.

In view of the plaintiff's difficulties, but without seeking to attach liability in all cases where the physician's conduct may have caused the injuries, the Commission "concluded that it is not unfair or unreasonable to place an onus on the physician to establish that he did conduct the necessary investigation and screening": *ibid.*, at 2-22. The reverse onus would serve "to induce physicians to conduct" such tests: *ibid.*, at 2-23. For the recommendations, see *ibid.*, at 2-24 to 2-25, recommendations II(10) and (11). See Draft Act, ss. 14-16. See, also, Draft Act, s. 8.

[104] *Ibid.*, at 2-19 to 2-20, recommendation II(9). See Draft Act, s. 13. See, also, Draft Act, s. 8.

The Commission further proposed that, "[w]here the semen used in artificial insemination is exclusively that of the husband of the recipient, the physician should not be required to comply with investigation and screening requirements, although he may decide to do so".[105] The Commission reasoned that "[t]he decision as to whether or not a woman should be inseminated with the semen of her husband is not ... a matter for regulation, but should be a matter of choice for the couple, made in consultation with a physician".[106]

The last section dealing with the legal position of physicians concerned the anonymity of semen donors not specifically chosen by the recipient. The Commission was of the view that disclosure of the identity of donors would discourage donations. Moreover, it stated that the identities of donors, recipients, and resulting children should not be known to each other, to avoid disrupting the lives of the families rearing A.I.D. children.

In view of what the Commission thought was the potential for these identities to become known — for example, in court proceedings — it recommended stricter regulation of the use of information contained in medical records. The Commission offered proposals designed to protect the confidentiality of anonymous donors, recipients, and A.I.D. children, without effectively precluding litigation by denying access to records that indicate the fact of artificial insemination. The Commission was of the view that, where records are admissible, the identity of an anonymous donor must not be disclosed.[107]

The final substantive portion of the Report dealt with the legal position of the recipient,[108] her husband, and the donor.

With regard to the husband, the Report first examined the law respecting child maintenance. Unlike the position under Ontario law, there is no obligation in Saskatchewan to maintain a child to whom one stands *in loco parentis*.[109] In order to "regularize" the relationship between the A.I.D. child and the recipient's husband, the Report recommended that "[w]hen a married woman is artificially inseminated with a donor's semen or with her husband's semen mixed with that of a donor, the resulting child should be treated in law for all purposes as a child of the husband if the husband has given prior consent to the artificial insemination".[110]

---

[105] *Ibid.*, at 2-18. See Comment to Draft Act, s. 4.

[106] *Ibid.* However, the Commission's statement did not really explain why, even though the actual decision to use A.I.H. might be that of the couple alone, the physician should not be required to comply with the investigation and screening requirements proposed in the case of A.I.D.

[107] *Ibid.*, at 2-27 to 2-28, recommendation II(12). See Draft Act, ss. 7 and 24. While the Commission acknowledged that "[s]ituations will arise ... in which the plaintiff or defendant's case would be facilitated if the semen donor were called as a witness", it concluded that "on balance, it is more important to protect the anonymity of semen donors than to facilitate judicial proceedings in those few cases where negligence is alleged": *ibid.*, at 2-26 to 2-27.

[108] With respect to whether A.I.D. constitutes adultery, see *infra*, note 111.

[109] See *Family Law Reform Act*, R.S.O. 1980, c. 152, ss. 16 and 1(e) (definition of "parent").

With respect to the maintenance obligation of a non-consenting husband, the Commission analogized to the position of a husband *vis-à-vis* the child of his adulterous wife or a child born as a result of sexual intercourse between his wife and another man prior to marriage. The Commission therefore recommended that the same child maintenance obligation should apply in these situations.[111]

Turning to the legal position of the donor, the Commission recommended that, "[e]xcept as provided in the following recommendation, a donor of semen should be deemed not to be a parent of a child born as a result of artificial insemination of a woman with his semen".[112] The Commission's following recommendation, dealing with the status of a donor who was not anonymous, provided that "[a] man who has supplied his own semen for use in inseminating a woman under an arrangement with the woman should be treated in law as the parent" of the resulting child if the donor knew or had reasonable cause to know that the mother was unmarried or was separated from her husband, or that the mother was married and her husband did not consent to the artificial insemination with the donor's semen. This support obligation would terminate when "an unmarried woman marries and her husband has legal support obligations to the child", or "the husband of a married woman has legal support obligations to the child".[113]

---

[110] Law Reform Commission of Saskatchewan Report, *supra*, note 74, at 3-8, recommendation III(1). See Draft Act, s. 19.

[111] *Ibid.*, at 3-8, recommendations III(2) and (3). See Draft Act, s. 21(a) and (b).

While the Commission stated that A.I.D. was "not likely" adultery, even without the husband's consent (*ibid.*, at 3-1), it was of the view that a declaration respecting this matter could have the effect of ensuring the retention of certain provincial rights that depend on whether a woman has committed adultery (*ibid.*, at 2-7). Accordingly, the Commission recommended that "[a]rtificial insemination through the use of a donor's semen should not constitute adultery": *ibid.*, recommendation II(5). See Draft Act, s. 18.

[112] *Ibid.*, at 3-14, recommendation III(4). See Draft Act, s. 22(1). See, also, Draft Act, s. 19(a), which provides that, where the recipient's husband has consented to A.I.D., "the donor other than her husband [in the case of a mixed donation] has no legal rights in respect of the child and has no legal obligations and duties as to the maintenance of the child".

[113] *Ibid.*, at 3-14 to 3-15, recommendation III(5). See Draft Act, s. 22(2) and (3). See, also, *ibid.*, at 3-15, recommendation III(6), and Draft Act, s. 23.

The Commission's rationale for drawing a distinction between the case where the recipient was unmarried or separated or where her husband did not consent, and the case where the recipient marries and her husband has a legal support obligation or a married recipient has a husband with such an obligation, was as follows (*ibid.*, at 3-9):

> If the recipient is married and her husband has consented to the AID, the donor should have no support obligations toward the resulting child since he can assume that the child will receive adequate financial support from the recipient and her husband. But, if he knowingly supplies semen to be used to inseminate an unmarried woman, or a woman who has failed to obtain the consent of her husband,

The Commission then turned to consider the liability of a donor for statements made to an examining doctor or recipient. While the Report had earlier advocated certain limitations on the rights of recipients and A.I.D. children against anonymous donors, special considerations were said to apply where an arrangement subsisted between the donor and the recipient. In such a case, the Commission recommended that the recipient and the resulting child should have a right of action against the donor for his negligent or fraudulent misrepresentation concerning his suitability as a supplier of semen, or for his failure to disclose his "knowledge of any disease, genetic condition, or medical condition in him or in blood relatives of his, whether alive or dead, which to his knowledge would or would be likely to render him unsuitable as a supplier of semen ...", so long as the donor's wrongdoing induced the recipient to consent to the insemination and the injury suffered resulted from the use of the semen.[114] The Commission buttressed these proposals by recommending that it should be an offence for a donor to conceal certain medical facts relating to his suitability as a donor.[115]

The last topic covered in the Report concerned the payment of donors. After briefly canvassing the arguments for and against payment — including the view that the prospect of payment might encourage concealment of diseases — the Commission observed that "the practical fact is that, if donors were not paid, the supply would dwindle and possibly disappear altogether"; accordingly, "legislation should seek to control the donor selection process to ensure that the risk of transmission of disease is minimized".[116]

(b) UNITED KINGDOM

(i) United Kingdom, Department of Health and Social Security, Scottish Home and Health Department, and Welsh Office

In 1972, an Advisory Group appointed by the United Kingdom Secretary of State for Social Services and the Secretaries of State for Scotland and Wales issued its report on *The Use of Fetuses and Fetal Material for Research*.[117] At the outset, the Advisory Group noted that "it is often difficult to distinguish between

---

> he occupies a position not unlike that of a man who has inseminated the woman by sexual intercourse. The fact that the semen was administered artificially provides a very weak basis upon which to draw a distinction. He has had direct control over the circumstances of the birth of the child, and therefore, should bear support obligations of a parent until some other person in addition to the mother is legally obligated to support the child.

[114] *Ibid.*, at 3-15, recommendation III(7). See Draft Act, s. 17.

[115] *Ibid.*, at 3-16, recommendation III(8). See Draft Act, ss. 5 and 24.

[116] *Ibid.*, at 3-13 to 3-14.

[117] United Kingdom, Department of Health and Social Security, Scottish Home and Health Department, and Welsh Office, *The Use of Fetuses and Fetal Material for Research: Report of the Advisory Group* (1972).

research uses and the diagnostic or therapeutic uses of the work which is being done".[118]

Much of the Report was not directly related to the subject of human artificial conception, since it dealt in large measure with research on the fetus *in utero*, viable fetuses, and dead fetuses. However, the Report also discussed research on the pre-viable fetus[119] and on fetal tissues and material.

Given its importance, the Advisory Group gave its *imprimatur* to research on pre-viable fetuses, under certain conditions. For example, such research should be conducted in hospitals and with the approval of their ethical committees; each ethical committee should first "satisfy itself: (a) on the validity of the research; (b) that the required information cannot be obtained in any other way; and (c) that the investigators have the necessary facilities and skill".[120] In addition, "no member of staff should be under any duty to participate in research on the fetus, fetal tissue or fetal material if he or she has a conscientious objection".[121]

With respect to payments, the Report stated that, aside from charges made to meet the "necessary costs incurred in administering" research facilities, no monetary exchange should be permitted.[122] The Report also proposed that "the relevant institutions should ensure that a record is kept of all ... material supplied or received and of its source and destination".[123]

When it turned to the future control of research, the Advisory Group reiterated its proposal that all research on pre-viable fetuses should be carried out only in hospital departments;[124] in addition, it should be approved by a committee of doctors with experience in clinical investigation.[125] The "committee should accept responsibility for ensuring that such investigations are ethical".[126]

---

[118] *Ibid.*, para. 8, at 2.

[119] While the Report appeared to be concerned mainly with a more fully developed pre-viable state than that represented by, for example, an ovum just fertilized, the broad definition of "fetus" to mean "the human embryo from conception to delivery" (*ibid.*, para. 6, at 2) would seem to make the proposals of the Advisory Group at least theoretically germane to our discussion.

[120] *Ibid.*, para. 35(3) and (4), at 8.

[121] *Ibid.*, para. 43, at 9.

[122] *Ibid.*, para. 44, at 9.

[123] *Ibid.*, para. 45, at 9.

[124] *Ibid.*, para. 47, at 10.

Finally, the Advisory Group considered whether research personnel ought to be specially licensed. The Report rejected such a system as "unnecessarily cumbersome". Instead, an easily amended "code of ethical practice would be an adequate safeguard".[127]

(ii) British Medical Association, Board of Science and Education, Panel on Human Artificial Insemination

In 1973, a Panel appointed by the British Medical Association reported on the legal and ethical issues respecting A.I.D.[128] With regard to these issues, the Panel noted that legitimacy and registration of births was first dealt with in the United Kingdom in 1960 by the Departmental Committee on Human Artificial Insemination, chaired by the Earl of Feversham.[129] A majority of the Feversham Committee had recommended that the law respecting these matters ought not to be altered, lest there be an increase in the practice of A.I.D. However, two dissenting members proposed that a child born as a result of A.I.D. to which the husband of the mother had consented should be legitimate, and that, for the purposes of birth registration, the husband should be deemed to be the father of that child.[130] The B.M.A. Panel wholeheartedly endorsed the dissenting position.[131]

---

[125] *Ibid*. The Report indicated that, in Hospital Memorandum (68)33, the Ministry of Health asked hospital authorities in England and Wales to arrange with the medical staff of their hospitals for a proposal of this type to be put in effect. See *supra*, note 117, para. 46, at 10.

It was suggested that, given the medical profession's code of practice, the disciplinary control over the profession, the general safeguards in the law, and the many purely medical factors involved, it was not necessary to have a lay member appointed to the ethical committees. Moreover, the Advisory Group did not believe it was necessary to establish a permanent, central body to deal with the limited number of cases that might arise where the hospital committee was uncertain of the ethics of a particular investigation: *ibid*., paras. 48 and 50, at 10-11. In lieu of such a body, the Report recommended that "arrangements should be made for a small informal advisory body with legal representation and including members drawn from the Medical Research Council, the Royal College of Obstetricians and Gynaecologists, the General Medical Council and the British Paediatric Association to be convened when the need for central advice arises": *ibid*., para. 50, at 11.

[126] *Ibid*., para. 47, at 10.

[127] *Ibid*., para. 49, at 10.

[128] British Medical Association, Board of Science and Education, "Appendix V: Report of Panel on Human Artificial Insemination", Brit. Med. J. Supplement 3, Vol. II, April 7, 1973, at 3 (hereinafter referred to as "B.M.A. Panel Report").

[129] United Kingdom, Home Office and Scottish Home Department, Departmental Committee on Human Artificial Insemination, *Report* (Cmnd. 1105, 1960). See B.M.A. Panel Report, *supra*, note 128, para. (5), at 3.

Whereas the majority of the Feversham Committee had recommended that the practice of A.I.D. not be regulated by law, the B.M.A. Panel stated that "[d]anger could arise from its widespread use without proper safeguards".[132]

While the Panel noted the steady increase in A.I.D. since the Feversham Committee Report,[133] it stated that "it is important not to exaggerate the justification for A.I.D.":[134] relatively few people would be suitable candidates. The Panel concluded that, before couples were accepted for A.I.D., there must be no way that couples could be helped other than by this procedure.[135] For such couples, "A.I.D. should be generally available within the National Health Service" (N.H.S.).[136]

Insofar as the provision of A.I.D. services was concerned, the Panel recommended that accredited centres should be set up within the N.H.S.,[137] although A.I.D. should not be limited to the N.H.S.[138]

Turning to the notion of licensing for A.I.D. doctors, the Panel was concerned that the relatively simple nature of the procedure would encourage "a too ready resort" to A.I.D. without adequate medical safeguards. However, the Panel rejected a system of licensing A.I.D. practitioners. It stated that existing investigatory and disciplinary machinery was sufficient to regulate the conduct of doctors.[139]

With respect to the selection of semen donors, the Panel endorsed the general practice of recruiting potential donors from the medical student population,[140] although it was stated that directors of accredited A.I.D. centres could choose any suitable donor, so long as he was prepared to have his medical and genetic history investigated.[141] The Panel also was of the view that such directors could authorize the use of fresh or frozen semen. Frozen semen should be stored in "the minimum possible number of banks".[142] To preserve anonymity, information concerning donors would be sent to accredited centres and to physicians in coded form, although "the banks would maintain complete records of their identity and medical history".[143] In order to preserve A.I.D. recipient anonymity, the Panel recommended that "[a] similar code of practice to that in operation for the maintenance of confidentiality of hospital records generally should be followed in the case of records of patients treated at accredited centres for A.I.D.".[144]

---

[130] See *ibid.*, para. (8), at 3-4.

[131] *Ibid.*, para. (8), at 4. See, also, *ibid.*, para. (34), at 5. This endorsement was later reaffirmed by the B.M.A.: see text accompanying notes 164-65, *infra*.

The only other legal aspect of A.I.D. considered in the Report related to the law of negligence. The Panel concluded that the law of negligence would apply to A.I.D. and that it was "unlikely that a court would find any reason for distinguishing between this [A.I.D.] and any other medical or surgical technique": B.M.A. Panel Report, *supra*, note 128, para. (9), at 4.

[132] *Ibid.*, para. (13), at 4.

[133] *Ibid.*, paras. (12)-(19), at 4.

[134] *Ibid.*, para. (18), at 4.

[135] *Ibid.*, para. (19), at 4.

[136] *Ibid.*

[137] *Ibid.*, para. (24), at 4.

[138] *Ibid.*

[139] *Ibid.*, para. (25), at 4.

[140] *Ibid.*, para. (26), at 5.

Finally, the Panel dealt with the monitoring of A.I.D. children. While it acknowledged the view that there should be no follow-up of such children, it did not entirely agree with this view. In order to obtain valuable genetic information and to learn the effects of A.I.D. on family life, the Panel recommended that "there should be properly conducted long-term follow-up of these families though it appreciates that there will be difficulties in instituting methods of follow-up which are effective and acceptable".[145]

(iii) British Medical Association, Working Group on In Vitro Fertilisation

In 1982, the British Medical Association Council established a Working Group to consider the social and ethical aspects of *in vitro* fertilization. The Working Group published its Interim Report in 1983.[146] This Report was amended, in part, in the Council's Annual Report for 1983-84.[147]

The 1983 Report first concluded that, given the rather low success rate of I.V.F., "these procedures should be carried out only in a few special centres in the United Kingdom, each providing the necessary special medical and backup scientific expertise supported by appropriate facilities, clinical and otherwise".[148]

---

[141] *Ibid.*, para. (27), at 5. Payment of a fee for the time spent at such an examination was considered to be a possibility, again at the directors' discretion: *ibid.* The Panel also suggested that, as a matter of practice, the prior consent of the donor's wife should be obtained: *ibid.*, para. (28), at 5.

[142] *Ibid.*, para. (31), at 5.

[143] *Ibid.*

[144] *Ibid.*, para. (35)(iv), at 5.

[145] *Ibid.*, para. (33), at 5.

[146] British Medical Association, Working Group on In Vitro Fertilisation, "Appendix VI: Interim report on human in vitro fertilisation and embryo replacement and transfer" (1983), 286 Brit. Med. J. 1594 (hereinafter referred to as "B.M.A. Working Group Report").

[147] British Medical Association, "Annual Report of Council 1983-4" (1984), 288 Brit. Med. J. 25 (special insert) (hereinafter referred to as "B.M.A. Annual Report").

[148] B.M.A. Working Group Report, *supra*, note 146, para. (14), at 1594.

The Report also stated that I.V.F. records should be kept confidential in the same way as the confidentiality of all other medical records is preserved.[149] However, while, for example, the names of patients and donors would be kept confidential, the details of any congenital abnormalities and numerical summaries for statistical purposes were recommended to be kept by the various Health Departments, "which, under the direct control of the chief medical officers, would hold the confidential central [I.V.F.] registers".[150]

With respect to the selection of couples for treatment, nonmedical criteria were stressed: "[t]he treatment of infertility by in vitro fertilisation and embryo replacement should be preceded by assessment of the stability of the family relationship of the couple concerned and of the sincerity of their intention to accept the duties and obligations of parenthood".[151] However, no mention was made of who was to make such an assessment.

In addition to giving its *imprimatur* to I.V.F. involving the gametes of both husband and wife,[152] the Working Group stated that, "[g]iven informed consent by all parties concerned", it was "not unethical" to use the procedure where a donor was involved.[153] The Report stated further that, while "rare", it "may be ethically acceptable" to use donated sperm and donated ova for I.V.F. where neither wife nor husband can produce viable gametes.[154]

The B.M.A. Report then turned to the use and disposition of embryos in excess of those needed to create a pregnancy. The Working Group recognized that, by observing such embryos, medical knowledge might be advanced and important genetic information, potentially helpful to the couple involved, might be obtained.[155] However, the Working Group first stated that the necessary observations of surplus embryos "should normally be completed within five to 10 days and always within a maximum of 14 days of fertilisation of the ovum by in vitro fertilisation".[156] It then proposed that "[t]he donors' wishes in relation to the ultimate disposal should, as far as possible, be respected".[157] With respect to frozen surplus embryos, "[s]torage should not exceed 12 months, and the couple's wishes in relation to ultimate disposal should, as far as possible, be respected".[158] The Working Group did not indicate why, in the case of non-frozen embryos, the "donors' " wishes should be taken into account, whereas, in the case of frozen embryos, the "couple's" wishes were to be consulted.[159]

---

[149] *Ibid.*, para. (5), at 1594.

[150] *Ibid.*

[151] *Ibid.*, para. (6), at 1594.

[152] *Ibid.*, para. (8), at 1594.

[153] *Ibid.*, para. (9), at 1594.

[154] *Ibid.* However, the Working Group did not indicate what persons were included in the phrase "all parties concerned". Would the spouse of a married donor have to consent? In addition, the Working Group did not explain why I.V.F. involving the donation of both semen and ovum "may" be ethically acceptable.

[155] *Ibid.*, para. (10), at 1594.

[156] *Ibid.* In the B.M.A. Annual Report, *supra*, note 147, para. (38.17)(i), at 25, the Council added the requirement that "[c]onsent to observation of fertilised ova in excess of those needed for embryo replacement or transfer should always be *obtained* ..." (emphasis in original).

[157] B.M.A. Working Group Report, *supra*, note 146, para. (10), at 1594.

The Working Group also addressed very briefly another controversial topic, namely, surrogate motherhood. Without any explanation, the Interim Report simply stated that "[t]he working group has yet to be satisfied that to undertake in vitro fertilisation with the sperm and ova of a couple and to transfer the embryo to the uterus of another woman who might carry the embryo to term on behalf of the couple will ever be acceptable".[160] In its Annual Report for 1983-84, the B.M.A. Council echoed this view. The Council stated that, "in consideration of the difficulties, anxieties, and uncertainties to all the individuals concerned, [the B.M.A. Council] considers that it is unethical for a doctor to become involved in techniques and procedures leading to surrogate motherhood".[161]

A further subject considered in the B.M.A. Report concerned genetic experimentation and research not specifically designed to deal directly with the problem of infertility. Again, the Working Group dealt with the matter summarily:[162]

> It is not ethically acceptable for medical practitioners to be involved in in vitro fertilisation and embryo replacement procedures in which the gametes (sperm or ova), embryos, or parts thereof are subjected to manipulations, including procedures designed to change their genetic make up or to induce the formation of multiple progeny ('cloning') if there is any intent to transfer the resulting embryos to a uterus.[163]

In an Addendum to the B.M.A. Interim Report, the Working Group offered some comments on A.I.D., although the topic was not within its formal terms of reference. It noted that an A.I.D. child is usually registered as if it were the natural child of the couple — a registration, it added, that was "contrary to English law", although "condoned as part of the present social scene".[164] It proposed that an A.I.D. child should be considered legitimate.[165]

---

[158] *Ibid.*, para. (11), at 1594. In the B.M.A. Annual Report, *supra*, note 147, para. (38.17)(ii), at 25, the Council added that "if a period of observation is intended after unfreezing and before disposal, consent for this should be obtained".

[159] A further control respecting surplus embryos was that "proposed programmes of observations on fertilised ova in excess of those needed for embryo replacement should be approved by the local ethical committee": B.M.A. Working Group Report, *supra*, note 146, para. (12), at 1594. Presumably, if the donor or the couple refused to allow such observation, these wishes would have to be respected, but this conclusion is not made clear.

[160] *Ibid.*, para. (13), at 1594.

[161] B.M.A. Annual Report, *supra*, note 147, para. (38.15), at 25.

[162] B.M.A. Working Group Report, *supra*, note 146, para. (14), at 1594.

[163] The implication appears to be that this type of experimentation would be ethically acceptable where the intent was "pure" research, and not embryo transfer. With respect to such research, the Working Group endorsed (*ibid.*, para. (15), at 1594-95) the guidance given by the Medical Research Council in "Research Related to Human Fertilisation and Embryology" (1982), 285 Brit. Med. J. 1480 (hereinafter referred to as "Medical Research Council Statement"), discussed in the following section of this chapter.

(iv) Medical Research Council

In 1978, the Medical Research Council set up an Advisory Group to review research involving I.V.F. and embryo transfer. The Advisory Group "advised the council that scientifically sound research involving in vitro fertilisation — where there was no intent to transfer the embryo to the uterus — should be allowed to proceed if its aim were clearly defined and acceptable". It also concluded that, where medically necessary, I.V.F. "should be regarded as a therapeutic procedure covered by the normal ethics of the doctor/patient relationship".[166] The Council endorsed these views.

In May 1982, an expanded Advisory Group was convened, and its conclusions, accepted by the Council, were published.[167] First, the Advisory Group essentially reiterated the earlier views on experimentation. It then expressed the opinion that donor consent, and the approval of the local ethics committee, should be obtained. Excess fertilized ova might be used for research, again with the consent of both donors. Finally, it was stated that fertilized ova "should not be cultured in vitro beyond the implantation stage; and should not be stored for unspecified research use".[168]

(v) Royal College of Obstetricians and Gynaecologists, Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer

In 1983, the Royal College of Obstetricians and Gynaecologists published a Report of its Ethics Committee on I.V.F.[169] The Report stated that it was "ethically acceptable"[170] to use I.V.F. in the context of a "marriage", defined as "a hetero-sexual couple cohabiting on a stable basis, whether or not legally married".[171] However, the Ethics Committee expressed "grave reservations" about the use of I.V.F. in other situations,[172] although it did not rule out the treatment of single women.[173] The rationale for the Committee's position related to the need for the resulting child to be in a "natural" two parent family.[174] The Report stated:[175]

---

[164] B.M.A. Working Group Report, *supra*, note 146, Addendum, para. (2), at 1595.

[165] *Ibid.*, paras. (3) and (5), at 1595. The Working Group also noted that "changes in the law in connection with artificial insemination from a donor might also provide protection in the analogous field of ovum donation" (*ibid.*, para. (6), at 1595).

[166] Medical Research Council Statement, *supra*, note 163, at 1480.

[167] Medical Research Council Statement, *supra*, note 163.

[168] *Ibid.*, at 1480. As indicated earlier, these guidelines received the endorsement of the British Medical Association in the B.M.A. Working Group Report, *supra*, note 146.

[169] United Kingdom, Royal College of Obstetricians and Gynaecologists, *Report of the RCOG Ethics Committee on In Vitro Fertilisation and Embryo Replacement or Transfer* (1983) (hereinafter referred to as "RCOG Report").

[170] *Ibid.*, para. 3.3, at 3.

> IVF and ER differs from other forms of treatment for infertility and puts extra strain not only on patients but also on doctors. The latter are not acting only as 'enablers'; in IVF and ER they are taking part in the formation of the embryo itself. That role brings a special sense of responsibility for the welfare of the child thus conceived. The Committee believes that most practitioners will intuitively feel that IVF and ER should be performed in the most 'natural' of family environments.

The Committee was categorical in its view that the decision to use I.V.F. is not for the couple alone; nor is it to be based exclusively on medical considerations:[176]

> A notional distinction may be drawn between parents who are unsuitable on medical grounds, whether physical, genetic or psychiatric, and those who may be considered unsuitable as parents on other grounds. There may be strong adverse indications of a social nature, or in the history of the marriage, which would seriously jeopardise the interests of the child to be born from the procedure, and hence outweigh the desires of the couple themselves. It remains the province of the doctor, in consultation with appropriate counsellors, to decide whether or not he should agree to their request. In so doing he would do nothing unusual. It is his normal procedure in other areas of practice; in abortion, for instance, within the loosely defined criteria set by the law; or in sterilisation, where yardsticks are applied which vary from doctor to doctor. Similarly it will remain the task of the doctor practising IVF and ER to assess and guide a couple as to their suitability for the procedure; and no doctor will wish, or can be compelled, to surrender his duty to make these judgments. Even under the NHS, where patients may claim consultation and advice, and seek alternative opinion as of right, they have no such right to any particular procedure if in the practitioner's reasonable judgment it ought not to

---

[171] *Ibid.*, para. 3.1, at 3. It is interesting that, in respect of A.I.D., Dr. B. Mason, a participant in an earlier RCOG forum, stated that the "couples that select themselves for A.I.D. are more stable than average": Brudenell *et al.* (eds.), *Artificial Insemination: Proceedings of the Fourth Study Group of the Royal College of Obstetricians and Gynaecologists* (1976) (hereinafter referred to as "Fourth Study Group"), at 57. With respect to the selection and counselling of A.I.D. recipients, see *ibid.*, at 80-96. The discussion dealt with, *inter alia*, the assessment of suitability for parenthood and whether doctors have the "right" or "responsibility" to select recipient couples. In the latter connection, reference was made to the doctor's role in protecting the interests of the future child.

[172] RCOG Report, *supra*, note 169, para. 6.1, at 6.

[173] *Ibid.*, para. 6.2, at 6. The Committee stated that, "in a society where a variety of family forms now exists and where adoption by single people, though rare, is possible it is felt that it would be wrong arbitrarily to exclude all single women from IVF and ER without consideration of their individual circumstances" (*ibid.*, para. 6.3, at 7).

[174] *Ibid.*, para. 6.4, at 7.

[175] *Ibid.*, para. 6.1, at 6. See, also, *ibid.*, para. 6.4, at 7.

[176] *Ibid.*, para. 3.5, at 4.

> be provided for them. The advice given, and its outcome, will reflect the integrity of those who counsel and the quality of their relationship with their patients; and this will remain true, whether resources remain limited and constricting or not.

The Ethics Committee saw "no legal or ethical difference" between I.V.F., using donor sperm or donor ova, and A.I.D.[177] In all cases, it recommended that the resulting children should be legitimized by deeming either the husband or the wife, as the case may be, to be the father or mother of the child.[178]

In connection with the legitimization of I.V.F. children, the Report recommended that "[t]he ovum donor should surrender all interests relating to her ovum in just the same way as the donor in AID does in regard to his sperm".[179] By implication, it appears that the sperm donor would also surrender his interests in the sperm. The Report stated further that the anonymity of donors must be maintained, and neither donors nor recipients should know of each other's identity.[180]

The RCOG Report then dealt with embryo donation where both the ovum and sperm are donated. The Ethics Committee saw the process as "analogous to adoption".[181] Accordingly, counselling would be required.[182] Indeed, the Report stated that, "[p]rovided that the appropriate administrative and counselling framework has been established, the Committee believes this form of adoption is ethically acceptable".[183]

With respect to surrogate motherhood, the Committee, while indirectly acknowledging that there might be thought to be "medical indications for surrogate motherhood in the case of a 'bad reproducer' ",[184] rejected the use of medical technology in this manner. The Committee was of the view that surrogate motherhood "carries important legal and psychological difficulties especially in relation to the child".[185]

---

[177] *Ibid.*, paras. 5.1-5.2, at 5.

[178] See *ibid.*, para. 5.2, at 5, and para. 14.2.2, at 15. But see Dunstan, in Fourth Study Group, *supra*, note 171, at 186.

[179] RCOG Report, *supra*, note 169, para. 5.3, at 5.

[180] *Ibid.*, para. 5.3, at 5, and para. 5.9, at 6. Accordingly, donation by a sibling or other relative or friend of the patient "is an undesirable practice and ... this form of donation would rarely be justified": *ibid.*, para. 5.9, at 6.

[181] *Ibid.*, para. 5.5, at 6.

[182] *Ibid.*

[183] *Ibid.*, para. 5.8, at 6. The reference to the "administrative" framework was not explained. With respect to the status of the resulting child, presumably, by extension, the previously mentioned deeming provision would legitimize him or her: see text accompanying notes 177-78, *supra*.

[184] RCOG Report, *supra*, note 169, para. 7.1, at 7.

[185] *Ibid.*, para. 7.2, at 7. See, also, *ibid.*, para. 7.6, at 8. The Report did not indicate what "legal and psychological difficulties" were envisaged.

The Report also focused on the surrogate mother. The Committee stated that "[a] change in her attitude and intentions [between implantation and birth] would create emotional stress in herself if she gives up the child or to the potential parents if she does not".[186] However, the Report later indicated that, with respect to surrogate motherhood agreements in the United States, "[t]he psychological impact on the surrogate is not known although no detrimental effect has been reported".[187]

After dealing with surrogate motherhood, the Ethics Committee turned its attention to record keeping. The Committee recommended the creation of a register, "with due regard to confidentiality", to include, for example, the details of parentage, a record of success or failure with different procedures, and information regarding the development of the child.[188] Even an "international register" was contemplated.[189]

With respect to the monitoring of the child, the Committee was "unanimous in its view that the physical follow up of babies resulting from IVF and ER is important".[190] However, at the time, it was "not considered practicable to follow up these babies from a psychological point of view or to compare them with a control series in any meaningful way".[191] This conclusion should be viewed in the light of the Committee's general wish to ensure that the children not be told of how they were conceived.[192]

Another matter canvassed in the RCOG Report concerned the freezing of embryos. The Committee stated that, while justifiable "in the hope of improving the success rate of IVF and ER",[193] "[i]t would be wise at first to limit the storage time to that required for a foreseeable and specific purpose e.g. a second pregnancy to the same couple".[194] "Such an arbitrary time limit", the Report continued, "is recommended on social rather than on scientific grounds and to avoid unpredictable legal hazards".[195] The Committee also recommended that,

---

[186] *Ibid.*, para. 7.3, at 7.

[187] *Ibid.*, para. 7.5, at 8.

[188] *Ibid.*, paras. 8.2-8.3, at 8.

[189] *Ibid.*, para. 8.4, at 9.

[190] *Ibid.*, para. 10.1, at 9.

[191] *Ibid.*, para. 10.4, at 9.

[192] *Ibid.*, para. 10.3, at 9.

[193] *Ibid.*, para. 11.3, at 11.

[194] *Ibid.*

[195] *Ibid.* The implication of the phrase "at first", and its relationship to the social and legal reasons why a time limit was suggested, were not examined; nor did the Report specify the "social ... grounds" for a time limit or the "unpredictable legal hazards" to be avoided.

"[t]o avoid the possibility of creating siblings unknown to one another, [the 'spare embryos'] should not be used for donor purposes".[196]

The Committee stated that "[g]uidelines or rules governing research investigations conducted on human embryos must reflect the status of the embryo in our scale of values".[197] It found that the view that life begins at conception, so that there is "a duty to respect the absolute inviolability of the embryo," is "difficult to sustain".[198] The Committee supported the views on research of the Medical Research Council,[199] and added that "[h]uman embryos employed in this way should not be allowed to develop beyond the stage of early neural development, (Day 17 after conception: Carnegie Stage 8) and such research should be subject to informed consent of the donor or donors".[200]

The final portion of the RCOG Report considered "the possible interface between the law and the practice of IVF and ET",[201] as well as problems relating to A.I.D. The Report dealt with the registration of persons carrying out these procedures and the licensing of premises where they are carried out. The Report acknowledged both the need to avoid placing unwarranted limits on infertility research and the need to preclude "commercial exploitation" of such research. Accordingly, the Committee recommended that "[a] statutory body should be established to advise the Secretaries of State on matters relating to in vitro fertilisation and embryo replacement".[202] On the advice of that body, the Secretaries of State would be given power to make the regulations relating, for example, to the licensing and inspecting of I.V.F. centres and practitioners and to experimentation.[203]

Several paragraphs were also devoted to a discussion of the legal status of semen, embryos, fetuses, and babies. The Committee recommended that "[w]hen sperm, ova or embryos are donated the donor should surrender all rights to interest or ownership".[204] Apart from "reasonable expenses", payment of donors would be forbidden.[205] The Commission proposed as follows:[206]

---

[196] *Ibid.*, para. 11.4, at 11. See, also, *ibid.*, para. 13.1, at 13.

[197] *Ibid.*, para. 13.3, at 13.

[198] *Ibid.*

[199] See Medical Research Council Statement, *supra*, note 163, para. (i), at 1480. See *supra*, this ch., sec. 2(b)(iv).

[200] RCOG Report, *supra*, note 169, para. 13.8, at 14. The Committee also dealt with "embryo division", that is, the "asexual reproduction aimed at producing multiple, genetically identical groups of cells and hence potentially viable off-spring": *ibid.*, para. 12.1, at 12. The Committee stated that it "accepts that attempts to detect defects by the above techniques are ethical, but sees no other indication for embryo division at the present time": *ibid.*, para. 12.4, at 12.

[201] *Ibid.*, para. 14.1, at 14. The term "embryo transfer" (ET) was used to refer to the case where an embryo is "implanted into a recipient other than the donor of the ovum": *ibid.*, para. 1.4, at 1.

[202] *Ibid.*, para. 14.3.4, at 16.

[203] *Ibid.*, para. 14.3.5, at 16.

> Stored semen (other than that produced for donor purposes) remains the property of the man until he requests its destruction. In the event of his death it remains part of his estate and is subject to the conditions of his will or, should he die intestate, would form part of his chattels and would pass to his widow. The possibility that she might subsequently wish to conceive a child using this semen might arise. Its use in other circumstances would have no justification.

The Committee stated that "[f]rozen embryos remain the property of the parents, who may wish and should be permitted to donate them anonymously subject to consideration of ethical use and public policy ...".[207]

With respect to storage, it was said that "clear guidelines should be established".[208] While a firm opinion could not yet be given, "[i]n the meantime [the ethics committee] advises doctors maintaining sperm banks to enter into a formal contract with those individuals 'banking' sperm so that all possible eventualities are covered".[209]

The final conclusions and recommendations of the Committee included the following:

> 6. The Committee does not consider that the question of research on or experimentation with early human embryonic material is a matter for the law. That problem is strictly an ethical one, in which it is necessary to be sensitive to public sentiment.[210]
>
> 7. The legal status of babies born following IVF and ER where the gametes are derived from the parents presents no problems.[211]
>
> 11. [T]he identity of donors should not be revealed and indeed the donor arrangements should be such that anonymity is inviolable .... [T]he decision to disclose to the child the nature of its parentage should at the present time remain with the 'legal' parents. This should apply equally to children resulting from AID or from IVF and ER. In the event of the parents making such disclosure the child should have access to the same information regarding the genetic background of the donor as was available to its parents without

---

[204] *Ibid.*, para. 14.4.1, at 16. See, also, text accompanying note 179, *supra.*

[205] RCOG Report, *supra*, note 169, para. 14.4.1, at 16.

[206] *Ibid.*, para. 14.4.3, at 16-17. It should be noted that, whereas "[s]tored semen ... remains the property of the man", and "no justification" arises for its use other than (perhaps) by his widow to conceive a child, frozen embryos, not to be transferred to the uterus of a woman, may be used for certain research purposes: see *ibid.*, para. 11.4, at 11, and para. 13.8, at 14. See, also, *ibid.*, para. 14.4.4, at 17.

[207] *Ibid.*, para. 14.4.4, at 17.

[208] *Ibid.*, para. 14.4.5, at 17.

[209] *Ibid.*

[210] *Ibid.*, para. 14.4.6, at 17.

[211] *Ibid.*, para. 14.4.7, at 17.

> breaching anonymity. If AID or IVF has been employed to avoid transmission of a genetic defect the parents should consider how this information can be conveyed to the child in the event of their premature deaths.[212]

(vi) The Law Commission

In 1979, the English Law Commission published its Working Paper on illegitimacy,[213] followed in 1982 by its final Report,[214] to which was appended a Draft Family Law Reform Bill.[215] The Commission dealt with A.I.D. only in its relationship to illegitimacy.[216]

The Law Commission Working Paper began with a basic statement that, under the present law, an A.I.D. child is illegitimate,[217] the donor being the legal father.[218] The "question therefore arises whether the law should be so framed that, in proper cases, it gives effect to the social reality (that is, that the child is the offspring of the husband and wife) rather than the genetic truth (that is, that he is the offspring of the wife and donor)".[219]

The Working Paper discussed the present practice of a majority of A.I.D. mothers of registering the husband as father. The Law Commission thought it was "unrealistic" to expect couples to resist the temptation to cover up the fact of A.I.D. in this manner. Accordingly, the Law Commission recommended in its final Report that "where a married woman has recieved A.I.D. treatment with her husband's consent, the husband rather than the donor should, for all legal purposes, be regarded as the father of a child conceived as the result; and that such a child should therefore not be 'illegitimate' ".[220] The Commission rejected as unreal and cumbersome the alternative of a special form of adoption to deal with the A.I.D. child.[221]

---

[212] *Ibid.*, para. 14.4.11, at 18.

[213] The Law Commission, *Family Law — Illegitimacy*, Working Paper No. 74 (1979) (hereinafter referred to as "Law Comm. W.P.").

[214] The Law Commission, *Family Law — Illegitimacy*, Law Com. No. 118 (1982) (hereinafter referred to as "Law Comm. Report").

[215] *Ibid.*, Appendix A, at 193 *et seq*. See s. 34, which covered the A.I.D. proposals.

[216] Law Comm. W.P., *supra*, note 213, para. 10.4, at 133.

[217] *Ibid.*, para. 10.1, at 132.

[218] *Ibid.*, para. 10.3, at 132.

[219] *Ibid.*, para. 10.3, at 133.

[220] Law Comm. Report, *supra*, note 214, para. 12.9, at 173 (footnote reference deleted). See, also, Law Comm. W.P., *supra*, note 213, para. 10.9, at 137. The Law Commission recommended "that the A.I.D. child should be treated as a child of the marriage and of the mother's husband unless it is proved to the satisfaction of any court which has to decide the issue that the husband did not consent to the A.I.D.": Law Comm. Report, *supra*, note 214, para. 12.24, at 178.

[221] *Ibid.*, para. 12.12, at 174, and Law Comm. W.P., *supra*, note 213, paras. 10.18-10.20, at 140-43.

Fundamental to the above proposal was the consent of the husband to the insemination. Two approaches were canvassed with respect to this issue, one requiring written consent, and the other adopting a presumption of consent.[222]

The first approach, focusing on the "legal consequences of the husband's consent", was animated by the principle that, if the consent "were to be effective, [it] would have to be in writing, in a prescribed form, and perhaps formally attested".[223] However, it was said that such a scheme would create a timing problem for the consent. Three possibilities were considered with respect to when consent could be effective: (1) whenever given; (2) only if given before the child's birth; or (3) only if given before the start of the treatment resulting in conception.[224] The Law Commission stated that the last alternative "is clearly desirable in the interests of fairness to the husband, but we doubt if it is sufficiently important in the interests of society as a whole to justify elevating it into a positive rule of law".[225]

Accordingly, the second approach was endorsed.[226] The Law Commission was concerned that hardship would be caused to the child where the husband had consented, but had neglected to meet the required formalities. Accordingly, "[i]t would be presumed that the husband had consented unless he (or anyone else with a sufficient interest) satisfied the court that he had not done so".[227] The Report continued by stating that, "although we believe that the practice of the Royal College, of requiring that consent be obtained before treatment is started, is a desirable rule of practice, we think it should not be mandatory".[228]

With respect to the preservation of the biological "integrity of the births register", the Law Commission considered whether "it should be provided that a husband should be deemed to be the father of an A.I.D. child if, but only if, a stipulated procedure for recording the A.I.D. conception were followed".[229] The Commission, in rejecting the annotation of the births register, noted two objections. First, the annotation would have to appear only where the husband of the recipient was clearly not the father. Secondly, many A.I.D. mothers would simply not use the procedure; rather, they would state that the husband was in fact the father.[230]

---

[222] See, generally, Law Comm. W.P., *ibid.*, paras. 10.12-10.16, at 138-40, and Law Comm. Report, *supra*, note 214, paras. 12.13-12.17, at 174-75.

[223] *Ibid.*, para. 12.14, at 174.

[224] The last alternative was said to represent the practice of the Royal College of Obstetricians and Gynaecologists: *ibid.*, para. 12.15, at 175.

[225] *Ibid.*, para. 12.15, at 175.

[226] *Ibid.*, para. 12.16, at 175. See, also, Law Comm. W.P., *supra*, note 213, para. 10.16, at 140.

[227] Law Comm. Report, *supra*, note 214, para. 12.16, at 175 (footnote reference deleted).

[228] *Ibid.*, para. 12.17, at 175.

[229] *Ibid.*, para. 12.18, at 176.

[230] *Ibid.*, paras. 12.19 and 12.21, at 177.

The Law Commission next dealt with the question "whether or not legal provision should be made so that the child would be entitled to ascertain the facts about his parentage".[231] It noted that, since the identity of the A.I.D. donor is confidential, access to any records by the child might not be of any real use to him. And to divulge the name of the donor would involve a substantial change of policy. The Law Commission concluded that, although the matter was outside the terms of reference, "[i]t may be that in time, if and when A.I.D. practice is regulated by statute, some right of disclosure may be thought appropriate".[232]

(vii) England, The Law Society, Standing Committee on Family Law, Human Fertilisation and Embryology

In 1983, the Law Society of England submitted a Memorandum[233] to a Departmental Inquiry chaired by Dame Mary Warnock.[234] Animating much of the discussion in the Memorandum was the need to regulate A.I.D.[235] For example, the Law Society noted the possibility of keeping a register of A.I.D. donors[236] and recommended a "system of recording the use of AID and of births resulting from it".[237] These suggestions would help to inhibit genetic incest and to bring A.I.D. "under some statutory control".[238]

When the Law Society turned to surrogate motherhood, it stated that "[i]t is by no means clear ... that the courts (which are not disposed to enlarge the existing fields of public policy) would necessarily hold that a contract based on AI was unenforceable — so far at least as it related to incidents other than those governing the destiny of the resulting child".[239] While what would be enforceable was not made clear,[240] the whole notion of such agreements was ultimately rejected. The Law Society stated that some way must be found to "[limit] a phenomenon which we consider thoroughly undesirable — womb leasing for which payment is made".[241] Indeed, the Society stated that "it is worth considering whether the time has come when it should become criminal for"

---

[231] *Ibid.*, para. 12.22, at 177.

[232] *Ibid.*, para. 12.23, at 177-78 (footnote reference deleted).

[233] England, The Law Society, *Memorandum by the Society's Standing Committee on Family Law: Human Fertilisation and Embryology* (1983).

[234] See discussion *infra*, sec. 2(b)(ix).

[235] *Supra*, note 233, para. 1.1, at 1.

[236] *Ibid.*, para. 2.2, at 2.

[237] *Ibid.*, para. 2.4, at 2. In passing, the Law Society stated that it did not favour any proposal that "AID children should be subject to some special form of adoption procedure" (*ibid.*).

[238] *Ibid.*, para. 2.5, at 3.

[239] *Ibid.*, para. 2.6, at 3.

[240] What if the child were given up to the couple, and the surrogate mother sued the couple for payment under the contract? Or what if, in the latter case, the surrogate mother breached a contractual term prohibiting smoking or consuming alcohol during pregnancy? Could such terms be enforced? See the English case of *A. v. C.*, unreported (June 20, 1978, H.C.J., Fam. Div.), where, in his *obiter* remarks, Mr. Justice Comyn stated that he regarded the surrogate motherhood agreement as "pernicious", as a purported contract for the purchase and sale of a child, and therefore void as against public policy.

> (a) a woman to offer, for reward of any kind, to bear a child for another person;
>
> (b) a man or a woman to offer such a reward to a woman;
>
> (c) a person to act as an agent or intermediary in such a transaction.[242]

The Law Society then commented that, "[w]hile the criminal law may require strengthening, the existing civil and family law is probably effective in making provision for any children that result ...".[243]

The final substantive section of the Memorandum dealt with the "manipulation of human genetic material". Once again, the emphasis of the Law Society was on the need for control.[244] The Memorandum considered whether genetic engineering should be prohibited, permitted, or permitted with controls.[245] The governing "best interests of the child" principle was said to preclude the "artificial creation of children" except in conformity with such interests,[246] and to preclude purely "scientific enquiry or investigation" except where, if carried full term into the generation of a child, "it would have been permitted as being in the best interests of the child".[247] This principle was also said "probably" to forbid "any other exercise of the [genetic] option (which clearly involves the use of human genetic and embryological material for experimental and possibly commercial purposes and raises profound legal problems which inter-relate with moral and social problems) ...".[248]

The Law Society stated that "all modern knowledge seems to point to the need of the child to establish wherever possible a clear identity for both its parents — that being the key to its own identity".[249] The Law Society then observed that, "applying the 'best interests' test, it would seem that any use of modern techniques that allows husbands and wives (and presumably also those permanently living together as such) to give birth by natural processes to children of their *own* which they *want* is consistent with the interest of the child and should be permitted".[250]

---

[241] *Supra*, note 233, para. 2.6, at 3.

[242] *Ibid.*, para. 2.7, at 3.

[243] *Ibid.*, para. 2.8, at 3. With respect to the legal status of the child, the Law Society mentioned, without comment, the Law Commission's proposal deeming the mother's husband to be the father of an A.I.D. child and the present general practice of registering the child as that of the mother and her husband: *ibid.*, para. 2.9, at 4.

[244] *Ibid.*, paras. 3.2 and 3.4, at 4.

[245] *Ibid.*, para. 3.5, at 5.

[246] *Ibid.*, para. 3.7(a), at 5.

[247] *Ibid.*, para. 3.7(b), at 5.

[248] *Ibid.*, para. 3.7(c), at 6.

[249] *Ibid.*, para. 3.9, at 6. The Memorandum cited the example of the right of adopted children in England to discover their natural parentage.

The Law Society then dealt with the use of modern techniques other than those that would allow couples to give birth to "their *own*" children:[251]

> Anything else, it would seem, should *NOT* be permitted for quite simply it savours of the *deliberate* creation of children to satisfy the demands of adoptive relationships — which tend to be less than ideal for the child and should not be encouraged. The fact that under our proposals it would be disallowed in the fields of genetic manipulation where high technical skills are required, though still feasible in the natural childbirth and AID field, should not gainsay the principle. It is probably undesirable from the child's point of view in the other fields — but not amenable to the same control.

The final paragraph in the Memorandum dealt with experimentation. The Law Society raised the possibility that experimentation might serve to benefit some future life, but then focused on cloning and related experimental work in its final discussion.[252]

(viii) Law Society of Scotland

In a response to a request by the Warnock Committee,[253] the Law Society of Scotland submitted its *Draft Submission on Government Inquiry into Human Fertilisation and Embryology.*[254]

While A.I.H. did not cause the Law Society any particular concern — since "any child so born must be a legitimate child of the two parties" — it did recommend that, where "there is consensual A.I.D., the child so born should be a legitimate child of the spouses".[255] With respect to unmarried women, the Law

---

[250] *Ibid.*, para. 3.10, at 6 (emphasis in original).

[251] *Ibid.*, para. 3.11, at 7 (emphasis in original).

[252] *Ibid.*, para. 3.12, at 7.

[253] See *infra*, sec. 2(b)(ix).

[254] Law Society of Scotland, *Draft Submission on Government Inquiry into Human Fertilisation and Embryology* (1983) (hereinafter referred to as "Law Society of Scotland Report").

[255] *Ibid.*, at 4 and 5. "If the husband does not consent any child so born would be illegitimate, but should be alimentable by the husband if he has accepted that child 'en famille' ": *ibid.*, at 5. The Report did not deal with the mechanics of the husband's consent. However, it did state that "[t]he question of the position of the medical practitioner where there was non-consensual A.I.D. is not one of law and although it has been raised in discussion at meetings of the working party, it is the view of the working party that this is a matter of ethics which should be referred to the General Medical Council": *ibid.*, at 6. It should be noted that the Report expanded the class of non-consensual A.I.D. to include the case where semen is used by the donor's wife after his death: *ibid.*, at 9.

Society stated that access to the procedure was "a matter of ethics"[256] — presumably, then, to be left to the medical profession.

The Report then turned to the issue concerning who ought to be authorized to carry out inseminations. The Law Society recommended that "insemination should be carried out by a registered medical practitioner or by a suitably qualified member of his staff, under his direct supervision".[257] The Law Society expressly declined to make any recommendation "regarding artificial insemination carried out in any other manner", although it did state that it would be "unnecessary and undesirable" to criminalize such activity.[258]

While the Law Society was willing to countenance control of the new technologies by the medical profession, it stood opposed to the importation of semen.[259] For example, where semen is stored, the storage should be only in "authorized" or "official" semen banks and "subject to statutory control".[260]

Like other bodies, the Law Society believed that confidentiality was "of paramount importance".[261] This view was related to the further proposal that "[t]he donor, if other than the husband, should have no rights in the child subsequently born, nor should the child have any rights in or claim to the 'father' or his estate".[262]

Another related issue concerned the consent of the relevant parties to the procedure. The Law Society endorsed the proposal of the Law Commission[263] that such consent should be presumed and "that anyone seeking to challenge such consent should have to satisfy a very high burden of proof".[264]

Insofar as I.V.F. was concerned, the Law Society generally saw "no additional problems ... beyond those already discussed in relation to A.I.H. and A.I.D."[265] However, the submission did expend some time considering the disposition of surplus embryos. After discussing the question whether they are "human matter or laboratory artifacts",[266] the submission supported the use of surplus embryos for research that would help to detect genetic defects in the child and so contribute to "the well being of the child".[267]

---

[256] *Ibid.*, at 8.

[257] *Ibid.*, at 6. While the Law Society was "opposed to indiscriminate use" of A.I.D. (*ibid.*, at 8), it did not see fit to interfere with control by the medical profession (*ibid.*).

[258] *Ibid.*, at 6.

[259] *Ibid.*, at 8.

[260] *Ibid.*, at 9.

[261] *Ibid.*, at 6.

[262] *Ibid.*

[263] Law Comm. Report, *supra*, note 214.

[264] Law Society of Scotland Report, *supra*, note 254, at 7.

[265] *Ibid.*, at 9.

[266] *Ibid.*, at 10.

At a later stage, the Law Society stated that it "[makes] no comments" on the "experimental use of human embryos"[268] (although it had earlier said that it was opposed to "any form of genetic engineering"[269]). The Law Society then commented that "[a]ny extension of experimentation on [a] pre-viable foetus should be subject to the normal laws regarding human experimentation, and in the view of the working party would require to form the subject of a special review".[270]

Also in the context of its discussion of "experimental matters", the Law Society stated unequivocally that it was "totally opposed to any proposal that artificial inseminatory techniques should be used for the purpose of cloning".[271] In addition, it was "opposed to any proposal that I.V.F. cloning or freezing techniques could be used to determine the sex of an embryo prior to its transfer to the uterus of the mother ...".[272] Indeed, the Law Society was "opposed to any proposed development of a technique to allow couples to choose the sex of their off-spring".[273] "Except for good medical grounds", the Report stated, "the working party are opposed to the killing of a foetus because of its sex".[274]

The Report also examined what it called "womb leasing",[275] that is, surrogate motherhood. The Law Society isolated three considerations respecting this matter.[276] First, there must be medical reasons for using this procedure. Secondly, the gestatory mother is the legal mother for all purposes.[277] Thirdly:

---

[267] *Ibid*. With respect to the time limits on the use of surplus embryos, the Law Society stated as follows (*ibid.*):

> The working party are persuaded that an embryo derives its humanity only after having established normal unity with its human mother. Prior to this, the working party would consider the embryo as no more than a laboratory artifact .... From a purely legal stand point ... it is submitted that it is essential that there should be legally defined terms to differentiate between a state prior to 'infusion with humanity' and that thereafter .... The dividing line is exceeding fine, but this must not be seen as a deterrent from drawing it. Undoubtedly this is a matter which must be kept under constant review.

[268] *Ibid.*, at 13.

[269] *Ibid.*, at 8.

[270] *Ibid.*, at 13.

[271] *Ibid.*, at 12.

[272] *Ibid.*

[273] *Ibid.*

[274] *Ibid*. In this connection, the Law Society said that "the provisions of Section 11(b) of the Abortion Act relevant to sex linked hereditary disease are sufficient ..." (*ibid.*).

The Law Society also referred to "certain studies [that] have been undertaken using human sperm and hamster eggs to differentiate between unexplained cases of male human infertility" (*ibid.*, at 13). The Law Society stated that it "[accepted] the limits on which this experimental technique has been used, but would be opposed to any extension thereof" (*ibid.*). Unfortunately, no reasons were advanced for restricting experimentation in this area.

[275] For the Law Society's definition of "womb leasing", see *ibid.*, at 2.

> (c) The 'sponsoring' parents must have a right of adoption. Here the Committee would differentiate between the circumstances where a woman is unable to bear a child and where she is both unable to bear a child and sterile. In the former case, because the fertilised ovum will be that of the wife, the 'sponsoring' parents should have an absolute right to adopt the child. This absolute right should only be available to the husband and wife jointly. If for any reason the right is exercised only by one parent it is no longer absolute but merely presumptive. In the latter case since the fertilised ovum will be that of the woman bearing the child, the 'sponsoring' parents should only have a presumptive and rebuttable right to adopt the child so born.

With respect to payment to the biological mother, the Law Society stated that, prior to birth, the mother "should only receive reasonable expenses to cover her pregnancy, including, where appropriate, compensation for loss of employment".[278] In addition, "[t]here should be a rebuttable presumption that all payments made during the pregnancy were made in support of the pregnancy".[279] After birth, however, payments should be required to be made "only ... when the baby is handed over".[280]

(ix) Department of Health and Social Security, Committee of Inquiry into Human Fertilisation and Embryology

In July 1984, a major study conducted by the Committee of Inquiry into Human Fertilisation and Embryology was published in the United Kingdom.[281] In light of the Committee's broad mandate to examine the social, ethical, and legal implications of the new reproductive technologies, it is understandable that it found considerable disagreement, both in the public at large and within the Committee, concerning many of the issues it addressed. Indeed, three formal expressions of dissent, one on surrogate motherhood and two on the use of human embryos in research, were included in the Report.

Yet, notwithstanding the controversial nature of the subject, the Committee found that "[w]hat is common ... is that people generally want *some principles or*

---

[276] *Ibid.*, at 11.

[277] The Report proposed that "the woman who gives birth to the child should be regarded in law as the mother, regardless of whether she was involved in the initial conception: *ibid.*, at 3.

[278] *Ibid.*, at 12.

[279] *Ibid.*

[280] *Ibid.* Presumably, such payments would still be related to "reasonable expenses to cover her pregnancy", although this is somewhat unclear.

[281] United Kingdom, Department of Health and Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (1984) (hereinafter referred to as "Warnock Report").

other to govern the development and use of the new techniques".[282] The Committee attempted to gauge the community sentiment and determine what it considered to be the public good, setting forth the arguments for and against various alternative approaches to reform. In doing so, however, the Committee clearly recognized that its conclusions could not reflect the diverse views held by all members of society.

The Report was divided into several chapters dealing with, *inter alia*, the Committee's general approach, the problem of infertility and its alleviation by such techniques as artificial insemination, I.V.F., egg and embryo donation, and surrogate motherhood, the storage of gametes and embryos, and embryo research.

In the main, the Committee was willing to leave many of the details involved in its proposals to be worked out later. Its recommendations were framed in more general terms, indicating, for example, where the law should intervene to regulate one practice or another. In this latter connection, it bears mentioning that the Committee foresaw "real dangers in the law intervening too fast and too extensively in areas where there is no clear public consensus".[283] With regard, however, to the fundamental question concerning the ethical status of artificial conception programmes, the Committee's basic view was that "actions taken with the intention of overcoming infertility can, as a rule, be regarded as acceptable substitutes for natural fertilisation".[284]

With respect to those persons who would be eligible to participate in an artificial reproduction programme, the Committee, while acknowledging the arguments of single men and women and those persons in homosexual or lesbian relationships, expressed the view that, "as a general rule it is better for children to be born into a two-parent family, with both father and mother, although we recognize that it is impossible to predict with any certainty how lasting such a relationship will be".[285] Insofar as the marital status of heterosexual couples was concerned, the Committee stated as follows:[286]

> It is sometimes suggested that infertility treatment should be available only to married couples, in the interests of any child that may be born as a result. While we are vitally aware of the need to protect these interests, we are not prepared to recommend that access to treatment should be based exclusively on the legal status of marriage.

---

[282] *Ibid.*, para. 5, at 2 (emphasis in original).

[283] *Ibid.*, para. 1.9, at 7.

[284] *Ibid.*, para. 2.4, at 9.

[285] *Ibid.*, para. 2.11, at 11-12. It is interesting to note that the Committee mentioned in passing the discrepancy between the proposed restrictions on artificial procreation expressed in the evidence presented to it — and reflected, in part, in its own recommendation — and the absence of any such restrictions in respect of fertile couples. "It has been argued", the Committee stated, "that the greater the degree of intervention in the creation of a child, the more responsibility must be taken for that child" (*ibid.*, para. 2.7, at 10). The Committee did not elaborate.

[286] *Ibid.*, paras. 2.5-2.6, at 10 (emphasis in original).

> In discussing treatment for infertility, this report takes the term *couple* to mean a heterosexual couple living together in a stable relationship, whether married or not. We use the words *husband* and *wife* to denote a relationship, not a legal status (except where the context makes differentiation necessary, for example in relation to legitimacy).

Not only would the Committee restrict eligibility, as a general principle, to married couples or to couples living in a stable union, but it also countenanced the rejection of certain otherwise eligible couples. In part, scarcity of services was said to impose on medical practitioners the need to grant priority to some persons over others, having regard to several factors, such as the patient's age. Indeed, the Committee seemed to go further; it stated that a practitioner may "consider that there are valid reasons why infertility treatment would not be in the best interests of the patient, the child that may be born following treatment, or the patient's immediate family".[287] The implications of this statement were made clear at a later juncture:[288]

> We recognize that this will place a heavy burden of responsibility on the individual consultant who must make social judgments that go beyond the purely medical ....

However, the Committee said that it was not possible to set out "the wider social criteria" to guide practitioners; each case must be decided on its own merits.[289]

Beginning with chapter 3, the Committee dealt with techniques for the alleviation of infertility. The Report first considered certain common threads running through all such techniques. For example, it was stressed that treatment should be undertaken "under the supervision of a registered medical practitioner".[290] With respect to the position of a gamete donor *vis-à-vis* the recipient couple, the Committee recommended anonymity at all times "as a matter of good practice".[291] All parties should be able to receive adequate counselling[292] and should be required to give their fully informed consent.[293]

In chapter 4, the Committee turned to artificial insemination. Except where a widow wished to use the semen of her deceased husband — which was considered in more detail in chapter 10 — the Committee saw no moral objection to A.I.H.[294]

---

[287] *Ibid.*, para. 2.12, at 12.

[288] *Ibid.*, para. 2.13, at 12.

[289] *Ibid.*

[290] *Ibid.*, para. 3.1, at 15.

[291] *Ibid.*, para. 3.2, at 15.

[292] *Ibid.*, paras. 3.3-3.4., at 15-16.

[293] *Ibid.*, para. 3.5, at 16. It appears that, "as a matter of good practice", the need for consent *in writing*, on "an appropriate consent form", would apply only "in the case of more specialized forms of infertility treatment" (*ibid.*). Precisely what was intended to be covered by this characterization was not made clear. See, also, *ibid.*, para. 4.23, at 25. As a matter of law, however, the husband's consent would be rebuttably presumed: see *ibid.*, para. 4.24, at 25-26.

In the case of A.I.D., more arguments could be marshalled against the practice. For example, the Committee noted that many persons believe that A.I.D. is violative of the marriage relationship, a threat to the family, and harmful to the child. The Committee accepted the notion that it would be detrimental to a child if he or she were to learn accidentally of the nature of the conception. The Committee opposed secrecy in this sense, but did not regard the potential for deception as an argument against A.I.D. itself.[295]

Moreover, and as a general principle, the Committee rejected the view that A.I.D. was necessarily disruptive of family and marital life. Indeed, at one point the Committee stated that "[i]t will often be true that A.I.D. with the consent of the husband is a mark of stability in a marriage ...".[296] The Report noted further that "those engaging in AID are, in their own view, involved in a positive affirmation of the value of the family".[297] Finally, it was said that "[a]n AID child is a child very much wanted ...".[298]

Not surprisingly, then, the Committee favoured the use of A.I.D. for infertile couples in appropriate cases, subject to its subsequent recommendations concerning licensing and other arrangements, described later.[299] The Committee recommended that the A.I.D. child should be treated in law as the legitimate child of the mother and her husband[300] where they have both consented to the insemination.[301] The husband's consent should be presumed, although the presumption should be rebuttable by the husband.[302] The Committee stated that, where "the mother is married and the husband consents to AID ... the law should be changed so as to permit the husband to be registered as the father".[303] The semen donor — who should remain unknown to the couple[304] — should have no parental rights or duties in relation to the child.[305]

---

[294] *Ibid.*, paras. 4.4-4.5, at 18.

[295] *Ibid.*, para. 4.12, at 21.

[296] *Ibid.*, para. 4.10, at 21.

[297] *Ibid.*, para. 4.14, at 22.

[298] *Ibid.*, para. 4.15, at 22.

[299] *Ibid.*, para. 4.16, at 23. The "provision of AID services without a licence for the purpose should be an offense" (*ibid.*).

[300] It bears repeating here that in this and other proposals, the terms "couple", "wife", and "husband" were given extended definitions unless otherwise indicated. See *ibid.*, paras. 2.5-2.6, at 10, reproduced in text following note 286, *supra*.

[301] Warnock Report, *supra*, note 281, para. 4.17, at 23-24.

[302] *Ibid.*, para. 4.24, at 25-26.

[303] *Ibid.*, para. 4.25, at 26. It should be noted that this recommendation applies only in the case of legally married persons.

The Committee added that, given the resulting effect on the births register (in England, hitherto envisaged as a true genetic record), "consideration should be given as a matter of urgency to making it possible for the parents in registering the birth to add 'by donation' after the man's name" (*ibid.*).

The Report further recommended that semen donors should be restricted as to the number of children that they may father. An arbitrary limit of ten children was suggested, to be monitored by a system of checking donors' National Health Service numbers against a proposed new centrally maintained list of N.H.S. numbers of existing donors.[306] With respect to the payment of donors, the Committee was concerned that payment of a fee would tempt some donors to withhold essential medical or other information. Accordingly, it recommended that "there should be a gradual move towards a system where semen donors should be given only their expenses".[307]

Chapter 5 of the Report dealt briefly with *in vitro* fertilization involving no donor gametes. While some of the arguments for and against I.V.F. were identical to those used in the context of artificial insemination, other arguments were unique to I.V.F. For example, the Report stated that many people are concerned about the ultimate disposition of embryos not transferred to a woman receiving artificial conception treatment.

The Committee's conclusion respecting I.V.F. mirrored that given in respect of A.I.D.: the practice "should continue to be available subject to the same type of licensing and inspection as ... recommended [in chapter 4] with regard to the regulation of AID".[308]

Chapters 6 and 7 considered, respectively, egg donation and embryo donation, the first involving I.V.F., the second involving either I.V.F. using donor gametes or *in vivo* fertilization and lavage. With respect to egg donation, the Committee thought it would be illogical not to accept the practice in light of its A.I.D. and I.V.F. proposals. The recommendation was as follows:[309]

> We recommend that egg donation be accepted as a recognized technique in the treatment of infertility subject to the same type of licensing and controls as we have recommended for the regulation of AID and IVF. The principles of good practice we have already considered in relation to these other techniques should apply, including

---

[304] Except where a man has donated semen, for example, specifically to provide for the artificial insemination of his brother's wife: see *ibid.*, para. 4.22, at 25. However, it was also recommended that, "on reaching the age of eighteen the child should have access to the basic information about the donor's ethnic origin and genetic health and that [non-retrospective] legislation be enacted to provide the right of access to this" (*ibid.*, para. 4.21, at 24-25).

[305] *Ibid.*, para. 4.22, at 25.

[306] *Ibid.*, para. 4.26, at 26-27. The proposed list would be held separately from the N.H.S. central register, to protect donor anonymity.

[307] *Ibid.*, para. 4.27, at 28.

[308] *Ibid.*, para. 5.10, at 32.

[309] *Ibid.*, para. 6.6, at 37.

> the anonymity of the donor,[310] limitation of the number of children born from the eggs of any one donor to ten, openness with the child about his genetic origins, the availability of counselling for all parties and informed consent.

The Committee further recommended that legislation should provide that the "woman giving birth should, for all purposes, be regarded in law as the mother of [the] child, and that the egg donor should have no rights or obligations in respect of the child".[311]

Embryo donation was regarded by the Committee as "probably the least satisfactory form of donation".[312] However, the Committee was prepared to accept this practice where it involved donated semen and ova brought together *in vitro*, again subject to the same type of controls recommended in respect of A.I.D., I.V.F., and egg donation.[313] On the other hand, the Committee recommended that "the technique of embryo donation by lavage should not be used at the present time",[314] although it would be acceptable once the risks of donation by this method have been overcome.[315]

Where a child is born by means of an embryo donation, the Committee recommended that the child should be treated in law as the child of the gestating mother.[316] With respect to the mother's husband, the Committee's proposal made applicable an earlier recommendation to the effect that "the law should be changed so as to permit the [consenting] husband to be registered as the father".[317] However, it is clear that the Committee also intended that a consenting husband should be the child's legal father. In its commentary following the proposal, the Committee expressed the view that "a child following embryo donation to a married couple will, in the eyes of the law, have that couple as parents".[318]

Chapter 8 of the Report considered the highly controversial question of surrogate motherhood. The Committee assumed that surrogate motherhood agreements would likely be treated by the courts as contrary to public policy and, therefore, unenforceable.[319] It was said that the weight of public opinion was in line with this likely legal treatment of such agreements. Once again, the Committee noted the argument that the practice was a violation of marital and familial bonds and was inconsistent with human dignity. Moreover, the potential harm to the resulting child was stressed.

---

[310] Except where this is not possible in practice, such as where the egg was donated by a sister or a close friend (*ibid.*, para. 6.7, at 37).

[311] *Ibid.*, para. 6.8, at 38. While the Committee did not make a specific proposal in respect of birth registration, it was clearly assumed that the gestating woman would be registered as the mother. However, as in the case of A.I.D., it was said that the parents should be permitted to use the words "by donation" after the mother's name: *ibid.*

[312] *Ibid.*, para. 7.4, at 40.

[313] *Ibid.*

[314] *Ibid.*, para. 7.5, at 40.

[315] *Ibid.*, para. 7.6, at 40.

[316] *Ibid.* Again, the words "by donation" could be appended: *ibid.*, para. 7.6, at 41.

[317] *Ibid.*, para. 4.25, at 26.

[318] *Ibid.*, para. 7.6, at 40.

[319] *Ibid.*, para. 8.5, at 43.

While the issue of surrogacy raised some of the most troublesome questions for the Committee, on one point it was unanimous: "surrogacy for convenience alone, that is, where a woman is physically capable of bearing a child but does not wish to undergo pregnancy, is totally ethically unacceptable". But, even where necessary to alleviate the consequences of infertility, the Committee raised moral objections to the practice, largely because of the "commercial exploitation of surrogacy".[320] The majority of the Committee even rejected the creation of a "limited, non-profit making surrogacy service, subject to licensing and inspection", for it was of the view that the existence of such a service would in itself encourage the growth of surrogacy.[321]

The Committee's main recommendations respecting surrogate motherhood were as follows:[322]

> We recommend that legislation be introduced to render criminal the creation or operation in the United Kingdom of agencies whose purposes include the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wish to utilise the services of a carrying mother; such legislation should be wide enough to include both profit and non-profit making organisations. We further recommend that the legislation be sufficiently wide to render criminally liable the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy.

While it was not envisaged that private persons entering into a surrogacy agreement would be liable to prosecution, a majority of the Committee proposed recommendations to ensure that all surrogate motherhood agreements remained illegal and unenforceable.[323]

The Committee then turned to consider the position of a child where, in a surrogacy situation, "the egg or embryo has not been donated but has been provided by the commissioning mother or parents with the intention that they should bring up the resultant child".[324] The Committee stated that, in such a case, the earlier proposals dealing with donated eggs and embryos should be made to apply. Accordingly, the woman giving birth, and not the prospective social mother, would be treated in law as the mother.

---

[320] *Ibid.*, para. 8.17, at 46.

[321] *Ibid.*, para. 8.18, at 46-47.

[322] *Ibid.*, para. 8.18, at 47.

[323] *Ibid.*, para. 8.19, at 47. Two members of the Committee dissented. They were of the view that, on "rare occasions", surrogacy could be justified "as a last resort" and, therefore, should be permitted (*ibid.*, para. 1, at 87). However, the proposed licensing authority should regulate and monitor such a practice; for example, it should license non-profit agencies that assist in making surrogacy arrangements (*ibid*). Courts should be empowered to consider individual surrogate motherhood agreements on their own merits (*ibid.*, para. 8, at 89). Payments to the surrogate mother in respect of her "services" "should not be a barrier to the child being adopted by the commissioning couple" (*ibid.*, para. 7, at 89). (In this latter connection, it appears that the dissenting Committee members envisaged that the acquisition of parental status would be by adoption only.)

With respect to the question concerning who would be the legal father, the Committee referred to an earlier proposal that "the law should be changed so as to permit the [consenting] husband to be registered as the father".[325] Presumably, then, adapting this recommendation to the surrogacy context, as envisaged by the Committee, the husband of the surrogate mother could — but need not — be registered as the father of the child.

One final point should be mentioned in the present context. The Committee stated that, "[i]f experience shows that [the proposals, just described, respecting who is to be the legal mother and father, give] rise to an injustice for children who live with their genetic mother rather than the mother who bore them then in our view the remedy is to make the adoption laws more flexible so as to enable the genetic mother to adopt".[326] Given the legal consequences of the Committee's earlier proposals, and their potential effect on such matters as support obligations, inheritance rights, and custody, it is not too difficult to foresee some "injustice" in many cases. Moreover, the Committee's proposals seem to run counter to its general predisposition in favour of certainty — particularly insofar as the welfare of the child is concerned — although the surrogacy proposal may have been regarded by the Committee as a necessary exception to the rule in light of its antipathy to the practice.

Whereas hitherto the Committee had dealt with the use of the new reproductive technologies to alleviate infertility, in chapter 9 the Committee considered the "wider use" of such technologies. For example, it recommended that "it should be accepted practice to offer donated gametes and embryos to those at risk of transmitting hereditary disorders".[327]

Another area canvassed was sex selection, where such practice could be of benefit in avoiding sex-linked genetic disorders, or where there were other sound medical reasons for choosing the sex of the child. The possibility that couples would seek sex selection for purely social reasons made the Committee "dubious about the use of sex selection techniques on a wide scale".[328] However, no firm proposal was made in this regard. The Committee restricted its one recommendation to "do-it-yourself" sex selection kits, stating that all such kits "should be brought within the ambit of control provided by the Medicines Act with the aim of ensuring that such products are safe, efficacious and of acceptable standard for use".[329]

---

[324] *Ibid.*, para. 8.20, at 47.

[325] *Ibid.*, para. 4.25, at 26, incorporated expressly in the recommendation contained in para. 8.20, at 47.

[326] *Ibid.*, para. 8.20, at 47.

[327] *Ibid.*, para. 9.3, at 49.

[328] *Ibid.*, para. 9.11, at 51.

Chapter 10 of the Warnock Report dealt with the freezing and storage of human semen, eggs, and embryos. While the Committee recommended that "the use of frozen semen in artificial insemination should continue",[330] it proposed that "the use of frozen eggs in therapeutic procedures should not be undertaken until research has shown that no unacceptable risk is involved".[331] The Committee also recommended that "the clinical use of frozen embryos may continue to be developed under review by the licensing body".[332]

The Committee then turned to consider nonmedical problems that might arise in respect of the storage, use, and disposal of frozen gametes or embryos. Reference was made to earlier proposals that would place the responsibility for disposing of the material on the storage authority, bearing in mind any express wish of the donor (for example, where storage was for the personal use of the man, woman, or couple). The Committee recommended as follows:[333]

> We recommend that there should be automatic five-yearly reviews of semen and egg deposits. We recommend that legislation provide that where a person dies during the storage period or cannot be traced at a review date the right of use or disposal of his or her frozen gametes should pass to the storage authority [bearing in mind any wishes of the donor].

In order to avoid inheritance and succession problems associated with posthumous fertilization, the Committee also proposed that "any child born by AIH who was not *in utero* at the date of the death of its father [should] be disregarded for the purposes of succession to and inheritance from the latter".[334] A similar proposal was made in connection with I.V.F. where a frozen embryo was used.[335]

With respect to embryo storage, the Committee also recommended a five-yearly review. In addition, because of medical, legal, and ethical considerations, it stated that there should be "a maximum of ten years for storage of embryos after which time the right to use or disposal should pass to the storage authority".[336] While the donor couple should have the right to the use and disposal of the embryo prior to the end of the ten year period, neither the couple nor anyone else should have a right of ownership in a human embryo.[337]

---

[329] *Ibid.*, para. 9.12, at 52.

[330] *Ibid.*, para. 10.1, at 53.

[331] *Ibid.*, para. 10.2, at 53. This last matter would be reviewed by the licensing body proposed in chapter 13.

[332] *Ibid.*, para. 10.3, at 54.

[333] *Ibid.*, para. 10.8, at 55.

[334] *Ibid.*, para. 10.9, at 55.

[335] *Ibid.*, para. 10.15, at 57.

[336] *Ibid.*, para. 10.10, at 56. The Committee was concerned, for example, with the disposal of embryos whose "parents" had died or divorced.

The Committee went on to propose that, where one of a couple dies, the right to use or dispose of a stored embryo should pass to the survivor; if both should die, the right should pass to the storage authority.[338] Where "there is no agreement between the couple the right to determine the use or disposal of an embryo should pass to the storage authority as though the ten year period had expired".[339]

In chapter 11, the Committee discussed the ethical and other arguments for and against the use of human embryos for either pure or applied research purposes — where, for example, such research was on embryos brought into existence by I.V.F. but not transferred to a uterus.

While the Committee accepted the notion that the embryo did not, and should not, have the same status as a living child or adult, it did state that no research should be undertaken on it where animals or other methods could serve the same purpose. Some legal protection should be afforded the human embryo.[340] While the majority of the Committee did not wish, then, to endorse a total prohibition on embryo research, such research and the handling of embryos would be permitted only under licence, with any unauthorized use of an embryo constituting a criminal offence.[341] The statutory licensing body would monitor the research and ensure compliance with the Committee's proposals.

A controversial area in respect of research concerns the time limit on keeping embryos alive *in vitro*. The Committee selected fourteen days after fertilization — excluding any time when the embryo was frozen — as the appropriate limit, based on what was thought to be the beginning of individual development of the embryo, which was said to occur at about fifteen days after fertilization. The Committee recommended that research on, or handling of, an embryo beyond this period should be a criminal offence. No embryo used for research purposes should be transferred to a woman.[342] Finally, the Committee stressed the need to obtain consent with respect to the method of use or disposal of surplus embryos. As a matter of good practice, no research should be carried out without informed consent, "whenever this is possible".[343]

---

[337] *Ibid.*, para. 10.11, at 56.

[338] *Ibid.*, para. 10.12, at 56.

[339] *Ibid.*, para. 10.13, at 56-57.

[340] *Ibid.*, para. 11.17, at 63.

[341] *Ibid.*, para. 11.18, at 64. Three members of the Committee dissented. They recommended that "nothing should be done that would reduce the chance of successful implantation of the embryo": *ibid.*, para. 3, at 90. More specifically, they would prohibit any experimentation on human embryos: *ibid.*, para. 5, at 91. Surplus embryos should be frozen, with a view to future implantation, or "allowed to die": *ibid.* The dissenting members justified their view mainly on the ground that an embryo has a potential to become a human being and, therefore, has a special status. See, also, *infra*, note 344.

[342] Warnock Report, *supra*, note 281, para. 11.22, at 66.

The final issue in chapter 11 was concerned with the difficult question whether research should be undertaken on embryos deliberately brought into existence for this purpose. The Committee canvassed the arguments for and against such research, including the argument that this practice would open the door to the creation of embryos for less valid purposes. Not all members believed that a distinction could be drawn between surplus and deliberately generated embryos. In some cases, a particular kind of research would effectively be precluded where reliance was placed on spare embryos alone. Despite a lack of consensus on all points, the Committee did agree that legislation, rather than the proposed licensing body, should deal with the issue. A majority recommended further that "the legislation should provide that research may be carried out on any embryo resulting from *in vitro* fertilisation, whatever its provenance, up to the end of the fourteenth day after fertilisation, but subject to all other restrictions as may be imposed by the licensing body".[344]

In chapter 12, some specific future research developments were canvassed, many of which were said to have caused public concern. In the case of trans-species fertilization, for example, the fear that a hybrid half-human creature might be created prompted the recommendation that such research be permitted by licence and only where the research was part of a recognized programme respecting infertility or subfertility. In no case should the embryo be allowed to develop beyond the two cell stage.[345]

Another area of concern was the use of human embryos to test drugs. While the Committee generally rejected the validity of such research — since it would require the creation of large numbers of embryos — it did accept the view that the proposed licensing body might endorse particular projects of this sort.[346]

Most of the remaining developments discussed by the Committee — such as cloning — were believed to be too speculative in nature to warrant specific proposals.[347] Moreover, several earlier recommendations, such as the proposal that would prevent research on embryos more than fourteen days after fertilization, would effectively prevent certain kinds of ethically unacceptable or suspect research. However, as a further safeguard, it was recommended that "the proposed licensing body [should provide] ... guidance on what types of research, apart from those precluded by law, would be unlikely to be considered ethically acceptable in any circumstances and therefore would not be licensed".[348]

---

[343] *Ibid.*, para. 11.24, at 66-67.

[344] *Ibid.*, para. 11.30, at 69. Four Committee members dissented from the view that research should be permitted on embryos deliberately created for this purpose or coming into existence as a result of other research (*ibid.*, at 94).

[345] *Ibid.*, para. 12.3, at 71.

[346] *Ibid.*, paras. 12.5-12.6, at 71.

[347] Although the Report did recommend, for example, that "the placing of a human embryo in the uterus of another species for gestation should be a criminal offence" (*ibid.*, para. 12.9, at 72).

The last chapter — chapter 13 — dealt with the actual regulation and monitoring of infertility services and research. The Committee recommended the creation of a new, independent statutory licensing authority, with lay representation and a lay chairperson, to regulate and monitor practice in the sensitive areas described in the Report.[349] The new body would have an advisory and an executive function, advising government, issuing guidance on good practice, publishing relevant information, granting licences, and overseeing inspections of licensed facilities.[350]

With respect to the licensing of infertility services — which should be supervised by "a qualified medical practitioner"[351] — the Committee recommended that "all practitioners offering the services that we have recommended should only be provided under licence, and all premises used as part of any such provision, including the provision of fresh semen and banks for the storage of frozen human eggs, semen and embryos should be licensed by the licensing body".[352] In addition to the functions described earlier, it was proposed that "the licensing body be asked to consider the need for follow-up studies of children born as a result of the new techniques, including consideration of the need for a centrally maintained register of such births".[353]

With respect to the licensing of research, the Committee stated that licences should be granted for individual projects for specified research in the field, with the licence to expire on the completion of the project. The licensing body would require "local ethical clearance" from the research institution and support for the work "by peer review undertaken by appropriate academic referees". Also proposed were tight controls on staffing and the reporting, for example, of the source and number of embryos used.[354]

The last topic considered by the Committee was the risk of commercial exploitation through the uncontrolled purchase and sale of human gametes and embryos. The Committee proposed that such purchase or sale "should be permitted only under licence from, and subject to, conditions prescribed by the licensing body and therefore unauthorized sale or purchase should be made a criminal offence".[355]

---

[348] *Ibid.*, para. 12.16, at 74.

[349] *Ibid.*, paras. 13.3-13.4, at 75-76.

[350] *Ibid.*, paras. 13.5-13.6, at 76.

[351] *Ibid.*, para. 13.8, at 77.

[352] *Ibid.*, para. 13.7, at 77.

[353] *Ibid.*, para. 13.9, at 78. Such a register would permit children to discover their origins and any information to which they are entitled. See, also, *ibid.*, para. 4.21, at 24-25; para. 6.6, at 37; and para. 7.7, at 41.

[354] *Ibid.*, paras. 13.10-13.12, at 78-79.

[355] *Ibid.*, para. 13.13, at 79.

(c) AUSTRALIA

(i) Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization

a. In Vitro Fertilization, Artificial Insemination, and Donor Gametes

In the early 1980's, the Victoria Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization published the *Report on Donor Gametes in IVF*,[356] as well as the prior *Interim Report*[357] and *Issues Paper on Donor Gametes in IVF*.[358] It should be noted at the outset that many important issues were identified, but not dealt with, by the Committee in these Reports — for example, the freezing and storage of embryos and the use of donated ova and sperm, surrogate motherhood, the fertilization of embryos for research and experimentation or for therapeutic purposes, and genetic engineering.[359]

The *Interim Report* concentrated its attention solely on I.V.F. using the gametes of the husband and wife. The Committee stated that it "considers this form of the procedure to be acceptable to the Victorian community and accordingly recommends that it be recognized in those terms".[360]

The subsequent Issues Paper dealt with A.I.D. and I.V.F. involving donor gametes. After reviewing the history and practice of I.V.F. and artificial insemination, the Issues Paper recanvassed the place of these procedures in Victoria. For example, the paper stated that "[t]hese techniques offer a better opportunity for establishing bonds between parents and child than does adoption, and they also offer greater scope than adoption for matching characteristics of parents and child".[361] In addition, the Committee suggested that "the child born as the result of sperm or ovum donation is likely to be especially well nurtured, since it is especially wanted".[362]

However, the Committee recognized that the tension involved in keeping the child's origins a secret, or the feeling that the child is a "foreign" person, may disrupt family life.[363] Moreover, "whether or not they [the couple] agree, their action is a denial of true sexual order.... It [A.I.D.] certainly is difficult to reconcile with the understanding of the unitive (as distinct from the contractual) nature of marriage".[364] Finally, the paper stated that "AID and ova donation are seen by some as departures from the age-old principle that the interests of the child are paramount, since they are not child-orientated but geared to satisfy the maternal and paternal instincts of the couple".[365]

---

[356] Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on Donor Gametes in IVF* (1983) (hereinafter referred to as "Victoria Report on Donor Gametes").

[357] Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Interim Report* (1982) (hereinafter referred to as "Victoria Interim Report").

[358] Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Issues Paper on Donor Gametes in IVF* (1983) (hereinafter referred to as "Victoria Issues Paper").

[359] Victoria Interim Report, *supra*, note 357, paras. 5.2-5.4, at 19-20.

[360] *Ibid.*, para. 5.6, at 20 (emphasis deleted).

[361] Victoria Issues Paper, *supra*, note 358, para. 3.2.6, at 14.

[362] *Ibid.*, para. 3.2.7, at 16.

Finally, in relation to the child, the Committee noted the argument that "children have a right to be brought into the world in the context which tends best to promote their individuality and responsibility and to promote their sense of identity ...".[366] This "sense of identity" might be impaired where the child's biological parents are not identical with its social parents. In this connection, the Committee stated that the "legislator may talk easily about erasing the legal link between genetic parent and child, but he cannot ignore the ethical right of the child to know its genetic antecedent".[367]

The Committee's *Report on Donor Gametes in IVF* did not review in any detail the matters raised in the *Interim Report* and Issues Paper. After a brief discussion, a majority of the Committee endorsed the use of donor sperm and donor ova in I.V.F.,[368] despite recognized differences between A.I.D. and

---

[363] *Ibid.*, para. 3.2.6, at 14.

[364] *Ibid.*, para. 3.2.5, at 14.

[365] *Ibid.*, para. 3.2.7, at 15. In this connection, the Committee commented that, in the legitimacy proposal in the English Law Commission Working Paper on illegitimacy, *supra*, note 213, "[t]he child is not mentioned": Victoria Issues Paper, *supra*, note 358, para. 3.2.7, at 15. The Committee's comment arguably reflects a rather narrow reading of one passage of the Working Paper. The point made in the latter document was that a mother using A.I.D. generally registers her husband as the father of the child. The Law Commission sought to recognize the social reality that the couple wants to treat the child as its own — generally not for the personal gratification of the husband and wife, but because they want to create a family unit, which presumably is in the best interests of the child.

Moreover, it seems somewhat myopic to view the proposal as essentially being related to anything other than the best interests of the child. The wish to remove any stigma of illegitimacy and regularize the status of the A.I.D. child is clearly an orientation in favour of the child.

[366] *Ibid.*

[367] *Ibid.*

[368] Victoria Report on Donor Gametes, *supra*, note 356, para. 2.6, at 10-11, and para. 2.9, at 12. The Rev. Dr. Francis Harman dissented with respect to the use of donor gametes (*ibid.*, Appendix A, at 49 *et seq.*). Having regard to the principle that the interests of the child are paramount, he stated that there were "higher-than-normal risks deriving from the trauma of [the child] discovering" his origins (*ibid.*, Appendix A, para. 8, at 54). In addition, he noted the "deception" practised by attempting to conceal origins. In his view, "IVF should be confined to the husband-wife dyad" (*ibid.*, Appendix A, para. 13, at 57).

I.V.F.[369] and despite special medical, surgical, social, and psychological problems associated with ova donation.[370]

However, in the *Interim Report*, it had been said that "[s]afeguards were needed to protect the interests of the community and the individuals involved in the programme, including the embryo formed in the laboratory".[371] For example, it was proposed that specially trained counsellors should advise couples on all matters relating to the treatment of infertility,[372] and should warn them that, in some cases, artificial conception procedures may involve some risk and may be traumatic, even where successful.[373] Such advice "will then permit each couple to express in writing their free and informed consent to participate in the programme".[374]

An important topic considered by the Committee was the selection of participants. The *Interim Report* was "of the view that the procedure should be available, at present, only to married couples",[375] although the door may have been left open for the future use of I.V.F. in the case of "de facto relationships".[376] This issue was not canvassed directly in the *Report on Donor Gametes in IVF.*

While many other bodies have recommended or assumed that an inquiry should be made into the suitability of the candidates for parenthood, the Committee was not clear on this point. It did insist that selection "should not be solely made on the basis of first in line or the capacity to pay".[377] But, by suggesting that selection "should be made on the basis of defined priorities relating to individual *needs*",[378] the *Interim Report* seemed to focus attention on matters other than the more amorphous ones relating to suitability for parenthood. In the *Report on Donor Gametes in IVF*, the Committee indicated that, in assessing the "need" of the couple, account should be taken of "not only medical but also social and psychological considerations".[379] Unfortunately, there was no further discussion of this important issue.

---

[369] For example, unlike in the A.I.D. case, where there is time for counselling, "[c]ouples in an IVF programme ... may be asked to make quick decisions, with little or no prior counselling on that subject, whether to accept the use of donor sperm, when fertilisation using the husband's sperm has failed to occur" (*ibid.*, para. 2.5, at 10).

[370] The Committee was "very conscious of the need to avoid any adverse discrimination against those couples whose infertility may only be managed through the use of donor ova" *(ibid.*, para. 2.9, at 12).

[371] Victoria Interim Report, *supra*, note 357, para. 5.8, at 21.

[372] *Ibid.*, para. 5.8.2, at 22-23, and Victoria Report on Donor Gametes, *supra*, note 356, para. 3.2, at 13-14. The two Reports also recommended the initiation by the government of a programme of information and education concerning infertility and "artificial" means of conception: see Victoria Interim Report, *supra*, note 357, para. 5.8.4, at 23-24, and Victoria Report on Donor Gametes, *supra*, note 356, para. 3.1, at 13.

[373] Victoria Interim Report, *supra*, note 357, para. 5.8.2, at 22-23, and Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.3-3.4, at 14-15.

[374] Victoria Interim Report, *supra*, note 357, para. 5.8.3, at 23. The Committee elaborated on this point in the Victoria Report on Donor Gametes, *supra*, note 356, para. 6.8, at 43:

> Consent to the use of donor gametes in IVF should be given, and recorded in a document, by the couple before they begin to participate in the procedures. A copy of the consent document should be given to the partners, and the original retained by the hospital.

See, also, discussion *ibid.*, para. 3.5, at 15-16.

[375] Victoria Interim Report, *supra*, note 357, para. 5.8.5, at 24.

[376] *Ibid.*

With respect to the person or body authorized to make a final decision concerning the screening of prospective recipients, it is interesting to observe that, in the Issues Paper, the Committee attempted to go beyond an uncritical approval of the medical profession's regulation of A.I.D. and I.V.F. The Committee's concerns deserve mention:[380]

> The Committee understands that the medical profession's regulation of insemination procedures extends to such fundamental social questions as the selection and screening of both donors and recipients, the maintenance of records (if any), and counselling (if any). It also extends to the destruction of records. There is a social interest in some form of regulation more comprehensive than that provided by individual members of the profession, or even by the ethics committees of specific hospitals. Medical ethics are not separate from but are part of the general moral and ethical order by which the whole community lives. Decisions as to what doctors ought to do must be tested against the ethical principles of society. They have no special dispensation to depart from our moral and ethical standards.

The Issues Paper, however, did not indicate the type of "more comprehensive" regulation suggested above or under whose aegis such regulation would take place.

In the *Interim Report*, the Committee attempted to protect the interests of the community and the persons involved in I.V.F. by recommending that "IVF should only be conducted in hospitals authorized to do so by, and responsible to, the Health Commission of Victoria".[381] The *Report on Donor Gametes in IVF* further suggested that the Health Commission establish procedures to monitor the authorized hospitals.[382] The Committee also made it clear that "the hospitals providing donor gametes in IVF programmes [should] ... retain a final responsibility for the admission of any patients to those programmes".[383]

The *Report on Donor Gametes in IVF* then turned to the donation of gametes. In view of the potentially unsettling effects of a donation, the Committee recommended that "the selection of donors shall be based not only on medical, but also on social and psychological considerations".[384] Prior to donation, prospective donors should be given "comprehensive information" on I.V.F. and the implications of gamete donation. In addition, donors should be told that, while they will have no legal relationship to the child and no duties or rights in respect of the child, there can be no guarantee of permanent, total anonymity.[385]

---

[377] *Ibid.* See, also, Victoria Report on Donor Gametes, *supra*, note 356, para. 3.6, at 16.

[378] Victoria Interim Report, *supra*, note 357, para. 5.8.5, at 24 (emphasis added).

[379] Victoria Report on Donor Gametes, *supra*, note 356, para. 3.6, at 16.

[380] Victoria Issues Paper, *supra*, note 358, para. 3.2.8, at 16.

[381] Victoria Interim Report, *supra*, note 357, para. 5.8.1, at 82.

[382] Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.40-3.41, at 30.

[383] *Ibid.*, para. 3.6, at 16.

With respect to the collection of gametes, the Committee stated that, prior to the donor's written consent, "it shall be unlawful for any gametes to be recovered".[386] In addition, a donor should be entitled to withdraw his or her consent upon "[f]ormal notice of withdrawal in writing" to the hospital.[387] On receipt of such notice, the hospital should "immediately dispose of those gametes, and make an appropriate record of that disposition".[388]

The Committee further recommended that "it [should] be unlawful to buy or to sell, or to agree to buy or to sell, any gametes",[389] although donors may be reimbursed "for any costs, including medical expenses they incur, in making the donation".[390] Moreover, "it [should] be unlawful to recover, or receive, any gametes from a child", that is, an unmarried person under eighteen years of age.[391]

The Committee had "reservations" about the use of known donors, having regard to the potentially harmful effect on the resulting child. But, given that some groups would not permit the use of gametes from unknown persons, the Committee recommended that "the use of known donors in IVF [should] be permitted where both partners specifically request that that be done".[392]

---

[384] *Ibid.*, para. 3.13, at 19.

[385] *Ibid.*, para. 3.14, at 19-20. In the penultimate section of the Victoria Issues Paper, the Committee dealt with the "uncertainty about the powers of donors of ova and sperm in respect of the use and disposition of gametes" (Victoria Issues Paper, *supra*, note 358, para. 3.4.8, at 26). The question whether, upon donating the gametes, the donor surrenders all rights to them — a matter that might arise where the donor wants the gametes back or applies for custody of the resulting child (see *ibid.*) — was identified, but not answered, by the Committee.

[386] Victoria Report on Donor Gametes, *supra*, note 356, para. 3.15, at 20.

[387] *Ibid.*, para. 3.17, at 21. See, also, Victoria Issues Paper, *supra*, note 358, para. 3.4.8, at 26, noted *supra*, note 385.

[388] Victoria Report on Donor Gametes, *supra*, note 356, para. 3.17, at 21. If the gametes have already been used, legislation should absolve the hospital and recipients of any criminal or civil liability as a result of such use: *ibid.*, para. 3.18, at 21.

[389] *Ibid.*, para. 3.10, at 18.

[390] *Ibid.*, para. 3.11, at 18.

[391] *Ibid.*, para. 3.12, at 18.

[392] *Ibid.*, para. 3.21, at 22. The donor should be subject to the same screening proposed

The Committee next turned to special matters respecting ova donation. In order to avoid pressure being placed on women participating in an I.V.F. programme to donate their surplus ova, the Committee recommended that "it [should] be unlawful to seek, or to use, ova ... soon after discovery that more have been recovered" than are necessary.[393] Further, "[c]onsent to the use of ova recovered must ... follow counselling and be obtained before any operation or other procedure for the recovery of those gametes".[394]

Several sections of the *Report on Donor Gametes in IVF* then proceeded to deal with the identification or anonymity of donors and recipients. This important matter was touched upon in the Issues Paper, where the Committee stated:[395]

> Donors should be helped to appreciate that records will be kept and subsequently details may be made available in certain cases. Records should be kept to include identity, health and social details. But the need to protect privacy remains. Accordingly certain records, it may be argued, should only be available to the people most affected, say, the child, the donor, and the recipients.

The details of what information could be given to these selected persons were not, however, disclosed.

In the *Report on Donor Gametes in IVF*, the Committee stated that donors and recipients should be provided with information thought to be important to them, without sacrificing anonymity. Accordingly, the Committee proposed that the hospital should offer "non-identifying" recipient information, including the results of the use of the gametes,[396] to the donor, and similar donor information to the recipient.[397]

With respect to anonymity *vis-à-vis* the resulting child, the Committee noted the tension between the need for secrecy and the "strong interest in being able to discover some information about [one's] origin".[398]

The Issues Paper considered the "psychological and social implications" of A.I.D. and I.V.F. from the perspective of both the couple and the child, whose interests were said to be paramount.[399] The Committee said that, "[i]n AID,

---

earlier in the Report, and "special counselling" should be given, with a separate document recording this fact: *ibid.*, para. 3.22, at 23.

[393] *Ibid.*, para. 3.25, at 24.

[394] *Ibid.*

[395] Victoria Issues Paper, *supra*, note 358, para. 3.3.6, at 21.

[396] Victoria Report on Donor Gametes, *supra*, note 356, para. 3.28, at 25.

[397] *Ibid.*, paras. 3.26-3.27, at 24-25. But see the dissent of Rev. Dr. Francis Harman (*ibid.*, Appendix A, at 49 *et seq.*), where he stated (para. 11, at 56) that "identifying information re donors should be available to the IVF/donor gamete product on attaining majority ...".

[398] *Ibid.*, para. 3.29, at 26.

[399] Victoria Issues Paper, *supra*, note 358, para. 3.3.1, at 17.

secrecy is being maintained, with possible tensions and conflicts between the parents, and between them and the child or children".[400]

In the *Report on Donor Gametes in IVF*, the Committee stated that "children born as a result of the successful use of donor gametes in IVF, should be able to discover some information about their origins".[401] However, while reference was made to the present view that, under certain circumstances, adopted children should be permitted to discover their natural parentage, "it is recognized that the considerations are not exactly the same as in adoption".[402] The Committee was concerned that emotional injury might result from overexposure to the facts.

The Committee proposed that the Health Commission should establish a central registry containing "comprehensive information". In addition, each authorized I.V.F. hospital should maintain its own register of donors, and should provide the Health Commission with information concerning successful pregnancies and any abnormalities found in I.V.F. children.[403] The Committee also proposed[404] that the "information in the registries [should] be exempt from the provisions of the *Freedom of Information Act* 1982[[405]]".

The Committee acknowledged that it had "not sought finally to determine ... what kinds of information, beyond that which is non-identifying, shall be provided by way of an entitlement to any person who enquires about her or his own genetic background".[406] Indeed, even the notion of "entitlement" appeared to be somewhat circumscribed, for the Committee stated earlier that any *request* for information should be made "on such terms and in such circumstances as the [Health] Commission from time to time shall determine".[407] However, it was recognized that the nature and scope of the information released would depend on the developing views of the Victorian community.[408]

---

[400] *Ibid.*, para. 3.3.4, at 19.

[401] Victoria Report on Donor Gametes, *supra*, note 356, para. 3.29, at 26.

[402] *Ibid.*, para. 3.30, at 26.

[403] *Ibid.*, para. 3.32, at 27.

[404] *Ibid.*, para. 3.36, at 28.

[405] No. 9859.

[406] Victoria Report on Donor Gametes, *supra*, note 356, para. 3.34, at 28.

[407] *Ibid.*, para. 3.33, at 27.

[408] *Ibid.*, para. 3.34, at 28. A further recommendation, related to the Committee's concern for "honesty and integrity in the family", was that "it [should] be unlawful to use donor gametes in IVF in such a way as to confuse those concerned about the genetic background of any child born": *ibid.*, para. 3.37, at 29. For example, "procedures such as the mixing of donor sperm, or the transfer of several embryos from different sources, should be prohibited": *ibid*.

The emphasis on the "integrity of the family" and the need to avoid genetic confusion prompted the Committee to deal with the possibility of incestuous relationships and sibling marriages arising from the indiscriminate use of donor gametes. It was thought

The next major portion of the *Report on Donor Gametes in IVF* dealt with the status of, and obligations to, I.V.F. children, matters considered briefly in both the *Interim Report* and the Issues Paper.

Where married couples used their own genetic material, the situation was said to be clear: the child was the legitimate issue of the marriage.[409] Where donor gametes were involved, the Committee rejected the possibility of using the cumbersome and expensive procedure of adoption to overcome the status of illegitimacy.[410]

In the *Report on Donor Gametes in IVF*, it was noted that, in July 1983, the Standing Committee of Commonwealth and State Attorneys-General respecting the status of A.I.D. children had considered a draft Artificial Conception Bill, prepared for the Attorney-General of Victoria. Section 4 provided that a consenting husband or common law partner was irrebuttably presumed to be the father of an A.I.D. child, and section 5 provided that the semen donor was irrebuttably presumed not to be the father. The Committee endorsed these principles, but stated that they should also apply where donor sperm or donor ova were used in I.V.F.[411]

The last section[412] of the *Report on Donor Gametes in IVF* dealt with a

---

that the existence and use of a central registry would significantly reduce these possibilities. For example, the Health Commission would be able to monitor the successful use of a donor's gametes in more than one I.V.F. programme, and to advise the hospitals accordingly: *ibid.*, paras. 3.38-3.39, at 29.

[409] Victoria Interim Report, *supra*, note 357, para. 5.9, at 26.

[410] Victoria Issues Paper, *supra*, note 358, para. 3.4.3, at 23, and Victoria Report on Donor Gametes, *supra*, note 356, para. 4.2, at 32.

[411] *Ibid.*, paras. 4.9 and 4.11, at 36. It should be noted that the Committee was of the view that, under the present law, the "mother of a child born as a result of the use of donor ova is the donor of the ova" (*ibid.*, para. 4.1, at 31). For a contrary view of the status of the gestating mother, see Law Society of Scotland Report, *supra*, note 254, at 11, para. (b).

The Victoria Issues Paper, *supra*, note 358, para. 3.4.11, at 27-28, also referred to recently proposed — although now lapsed — legislation in Australia to amend the federal *Family Law Act* 1975, No. 53. Section 5A(1) of the 1981 *Family Law Amendment Bill* provided, *inter alia*, that the consenting husband of a woman who was an A.I.D. or I.V.F. recipient shall be the father of the resulting child. The Committee noted that the language of clause (a) "[seems] to mean that consent must be given before AID or AID-in-IVF is carried out": Victoria Issues Paper, *supra*, note 358, para. 3.4.11, at 28.

We shall return to the legislation in Victoria at a later juncture: see *infra*, sec. 3(d)(i).

[412] Prior to this, the Committee completed its discussion concerning the status of I.V.F. children by indicating that it had not considered other matters of law identified in the Issues Paper: Victoria Report on Donor Gametes, *supra*, note 356, para. 4.13, at 37. For example, the Committee discussed briefly prenatal and other personal injury actions against medical personnel and donors. Further study was said to be necessary in respect of many of these matters: *ibid.*

matter thought to demand special attention, that is, the use of donor embryos, as opposed to donor sperm or donor ova.

The issue was considered briefly in the *Interim Report*, but there was no clear statement by the Committee. A minority believed that, "until the Committee has had time to consider fully the implications of alternatives such as freeze thawing of embryos, donation of embryos, and surrogate motherhood, ... these procedures should not be employed in IVF programmes in Victoria".[413] However, the majority endorsed the process of freeze thawing "while this is being considered".[414] Moreover, it was of the view that, where there were surplus embryos, "the wishes of the couple concerning handling of such excess embryos should be respected".[415]

In the *Report on Donor Gametes in IVF*, the Committee stated that its examination of the issues relating to the freezing of embryos had not been completed. However, it recognized that, given the potentially unsettling effect on the child and couple, embryo donation was of more concern than the donation of sperm or ova alone. While, initially, the Committee said that the statements in the *Interim Report* represented its only observations to date,[416] a majority of the Committee nonetheless recommended that the use of donor embryos should be permitted. In particular, the majority was "conscious of the need to avoid discrimination against those couples whose infertility may only be managed through the use of donor embryos".[417]

In addition to recommending that its previous proposals concerning the regulation of the use of donor sperm and donor ova should apply to the use of donor embryos,[418] the Committee made several other recommendations with respect to the latter.[419] For example, the Committee said that "[i]t should be unlawful for donor embryos to be used except in the case of couples whose infertility cannot be overcome by other means, or where the couple may transmit undesirable hereditary disorders".[420]

---

[413] Victoria Interim Report, *supra*, note 357, para. 5.8.6, at 26.

[414] *Ibid*.

[415] *Ibid*., para. 5.8.6, at 25.

[416] Victoria Report on Donor Gametes, *supra*, note 356, para. 5.3, at 39.

[417] *Ibid*., para. 5.5, at 40. It will be recalled that this was the rationale used to justify the proposal respecting the use of donor ova: see *supra*, note 370.

Rev. Dr. Francis Harman and Mrs. Jasna Hay dissented. Both expressed concern for the welfare of the child whose genetic makeup did not come from either of the social parents.

[418] Victoria Report on Donor Gametes, *supra*, note 356, para. 5.6, at 41.

[419] *Ibid*., paras. 6.32-6.35, at 47-48.

[420] *Ibid*., para. 6.32, at 47.

b. In Vitro Fertilization and "Surplus" Embryos

In its *Interim Report*, the Victoria Committee had identified certain matters relating to the disposition of embryos in the context of I.V.F. It decided that, subsequent to its *Report on Donor Gametes in IVF*, it would consider the cryopreservation of embryos, experiments on embryos, and surrogate motherhood using I.V.F. Accordingly, in 1984, the Committee published its *Report on the Disposition of Embryos Produced by In Vitro Fertilization.*[421]

After first discussing generally the freezing of gametes and embryos, the Committee noted that it was divided concerning developments in genetic manipulation, particularly those that would permit the treatment and cure of embryos *in vitro* so that they might be transferred to recipients. However, the Committee was unanimously of the view that the subject of genetic manipulation of untransferred embryos deserved further study.[422]

When the Committee returned to the topic of embryo freezing, it noted the arguments both for and against the process. For example, one member of the Committee believed that the embryo, unlike the individual gamete, represented human life, and that freezing and storing it "is to derogate, grossly, from [its] intrinsic worth".[423] In addition, it was suggested that the physical risks of freezing and thawing, and the effect on the future child who learns that, for a time, he or she was in "suspended animation", also militated against cryopreservation.[424]

The main argument marshalled in favour of the process was a simple one: "the procedure is successful and it does presently facilitate the operations of [an I.V.F.] programme".[425] Indeed, the Report noted that, for some persons, cryopreservation is essential, where, for example, it is impossible or medically undesirable or impracticable to transfer an *in vitro* embryo immediately to the intended recipient. To permit the embryo to be wasted might necessitate, among other things, a further laparoscopy under general anesthetic. In this connection, the Committee stated, it must be borne in mind that most transfers do not, in fact, result in a pregnancy; accordingly, cryopreservation reduces the economic and emotional burdens involved in I.V.F. treatment. Moreover, embryo freezing may permit couples to have children subsequent to radiation therapy or chemotherapy undergone by one of them, since such therapy usually results in sterility.

The Committee, by a majority, recommended that "the freezing of embryos formed in an IVF programme should be permitted in Victoria at present", in accordance with further proposals made in the next part of its Report.[426] As indicated, there was one dissent.[427] Moreover, one Committee member was in favour of freezing only where the health of the intended recipient did not permit an immediate embryo transfer.[428] In order to reduce the need to freeze embryos, all members of the Committee were of the opinion that "research on and development of techniques for the freezing and storage of human ova should be warmly encouraged".[429] Should such techniques be perfected, the question of embryo freezing "should appear as an item on the agenda of a standing review and advisory body on human fertility, reproduction and related subjects",[430] proposed in Part 5 of the Report.

---

[421] Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on the Disposition of Embryos Produced by In Vitro Fertilization* (1984) (hereinafter referred to as "Victoria Report on Embryos").

[422] *Ibid.*, para. 1.17, at 14.

[423] *Ibid.*, para. 1.28, at 18. See, also, *ibid.*, Appendix A, at 62.

[424] *Ibid.*, para. 1.30, at 18-19.

[425] *Ibid.*, para. 1.31, at 19.

Since the Committee took the position that embryo freezing was still experimental,[431] it was of the view that "the greatest caution must be exercised in the management and control of that programme".[432] More specifically, it stated that "the overriding consideration must be to restrict as far as possible the period of cryopreservation", while bearing in mind the needs of infertile couples.[433] However, it was not made entirely clear why the majority of the Committee believed that a time limitation was necessary, once freezing had taken place, particularly since the majority thought that "[f]reezing is not inimical to the interests of the embryo".[434] One rationale, discussed earlier,[435] related to the psychological effect of cryopreservation on the future child. But it was not stated why the actual duration of cryopreservation, as opposed to cryopreservation itself, was relevant to the child's attitude to the facts of its origin. Another reason for imposing a time restriction was, apparently, that short term storage would reduce the risk of problems that might occur where, for example, the couple died or ceased to cohabit.[436]

With respect to the "management and control" of embryo cryopreservation, the Committee recommended that freezing and storage of embryos should be carried out only "if the couple whose gametes have been used in its formation" agreed in writing to the procedure;[437] moreover, it should "only be undertaken in a hospital already approved to conduct an IVF programme, which is specially authorized by the Minister of Health to conduct such activities".[438] Moreover, "no hospital authorised to conduct a cryopreservation programme shall maintain a bank or store of large numbers of frozen embryos from which embryos may be disposed of as the hospital thinks fit";[439] rather, "[e]ach embryo which is frozen shall be retained for a couple, to be used in the course of the treatment of their infertility".[440]

---

[426] *Ibid.*, para. 1.40, at 22.

[427] See *supra*, note 423 and accompanying text.

[428] Victoria Report on Embryos, *supra*, note 421, para. 1.38, at 21-22. See, also, *ibid.*, Appendix B, at 72.

[429] *Ibid.*, para. 1.43, at 23.

[430] *Ibid.*

[431] *Ibid.*, para. 2.1, at 24.

[432] *Ibid.*

[433] *Ibid.*

[434] *Ibid.*, para. 1.32, at 19.

[435] *Ibid.*, para. 1.30, at 19. See text accompanying note 424, *supra*.

[436] Victoria Report on Embryos, *supra*, note 421, para. 2.14, at 30-31. See discussion *infra*, this sec.

[437] Victoria Report on Embryos, *supra*, note 421, para. 2.7, at 26. The agreement could be

However, the Committee did "not regard the couple whose embryo is stored as owning or having dominion over that embryo",[441] although it did say that the couple should have rights over the embryo analogous to parental rights.[442] Nevertheless, these rights of disposition, which should be indicated prior to cryopreservation,[443] would not be absolute. For example, the couple could not "sell or casually dispose of the embryo".[444] But the couple might donate the embryo for an I.V.F. programme or for I.V.F. research or experimentation,[445] or might simply decide that the storage should cease.

Where the couple exercised its rights of disposition in any one of these ways, "the embryo shall be removed from storage as soon as possible".[446] If storage was simply to cease, the embryo "should not be destroyed in any deliberate fashion", but, like a terminally ill person whose life-support systems have been removed, should be allowed to die.[447]

Ordinarily, it was said, storage should be for a very short time. However, cases might arise where longer term cryopreservation was necessary, for example, where the intended recipient was undergoing chemotherapy. Where "a couple consents to long term storage, the consent shall be reviewed after 5 years, and may then be renewed".[448]

Long term storage was said to increase the risk of problems that might occur, for example, where one or both of the gamete donors died or disappeared,

---

made only after the couple has been given adequate information concerning the procedure and has received "expert counselling": *ibid*. See, also, *ibid*., paras. 2.4-2.6, at 25-26.

[438] *Ibid*., para. 2.2, at 24.

[439] *Ibid*., para. 2.3, at 24-25.

[440] *Ibid*., para. 2.3, at 25.

[441] *Ibid*., para. 2.8, at 27.

[442] *Ibid*.

[443] *Ibid*., para. 2.9, at 28.

[444] *Ibid*., para. 2.8, at 27-28.

[445] *Ibid*., para. 2.8, at 28. See, also, *ibid*., paras. 2.10-2.11, at 28-29.

[446] *Ibid*., para. 2.12, at 29.

[447] *Ibid*. "This does seem to accord the embryo a measure of that respect which is so often spoken of in relation to it": *ibid*.

[448] *Ibid*., para. 2.13, at 30.

or where the parties ceased to cohabit.[449] The Committee decided that the disposition of the stored embryo should not be determined by the hospital holding it, since this might lead to the undesirable establishment of a hospital embryo bank.[450] The Committee further recommended that "the couple who agree to storage shall be required to determine at that time what disposition shall be made if any of the events mentioned occur".[451] Where, for some reason, the intended disposition could not proceed, or no provision had in fact been made, "the embryo shall be removed from storage"[452] (and, therefore, permitted to die).

The Committee next turned to consider embryo research, which was said to be essential to the success of I.V.F. The Committee mentioned several areas, relating, for example, to the treatment of infertility and congenital defects and other diseases, that depended on embryo research.

The members of the Committee were divided regarding such research. A minority was of the view that "any research on embryos which prevents implantation, or reduces the success rate of such implantation, is unacceptable, as is the creation of embryos specifically for research where there is no intention that the embryo created should be transferred to a recipient uterus".[453]

A majority of the Committee, however, concluded that, if regularly scrutinized, embryo research was acceptable in order to improve I.V.F. procedures and evaluate genetic research. For example, the successful development of ovum freezing would help to reduce substantially the ethically difficult questions respecting the use of surplus embryos. The majority recommended that the "use of any embryo for research [should] be immediate, and in an approved and current project in which the embryo [should] not be allowed to develop beyond the stage of implantation, which is completed 14 days after fertilization".[454]

Several Committee members would limit embryo research "to the excess embryos produced by patients in an IVF programme",[455] for example, where abnormal embryos are not transferred to a woman; embryos should not be created solely for research or experimentation.[456] Others recommended that research should not be limited to surplus embryos, but could encompass embryos created purely for research purposes, in order to facilitate certain kinds of study.[457]

---

[449] *Ibid.*, para. 2.14, at 30-31.

[450] *Ibid.*, para. 2.16, at 31-32.

[451] *Ibid.*, para. 2.17, at 32.

[452] *Ibid.*, para. 2.18, at 32.

[453] *Ibid.*, para. 3.24, at 45.

[454] *Ibid.*, para. 3.29, at 47.

[455] *Ibid.*, para. 3.26, at 46.

[456] *Ibid.*, para. 3.27, at 46.

[457] *Ibid.*, para. 3.30, at 47-48.

The Committee next turned to consider surrogate motherhood in the context of I.V.F. The Committee came to the conclusion that "surrogate mother arrangements where fees are paid are, in reality, agreements for the purchase of a child, and should not be countenanced".[458] Characterizing commercial surrogacy arrangements, involving payment of a fee to the surrogate mother, as more "inhuman" than the sale of gametes, the Committee stated that a "hospital licensed to conduct an IVF programme [should] not be permitted to make any commercial surrogacy arrangements as part of that programme".[459]

On the other hand, the Committee noted that "surrogacy in IVF [presumably using the gametes of the intended social parents] may commend itself more than the use of donor gametes in IVF to some couples", since a "child born would be genetically theirs, and ethical problems about disclosure and identity would be avoided".[460] In the end, however, the Committee recommended that "surrogacy arrangements [should] in no circumstances be made at present as part of an IVF programme in Victoria",[461] even where the surrogate mother is not paid a fee. The Committee recognized the utility of such arrangements and that the surrogate mother might be acting altruistically. However, its concern for the child, the potential discord where a handicapped child is born, and the problems associated with the failure to surrender the child convinced the Committee that surrogate motherhood arrangements of any kind should be prohibited.

The last substantive part of the Report dealt with future developments and further issues, some of which had not been considered by the Committee in detail, although identified in the *Interim Report*. In addition, the Committee emphasized that advances in research and practice would have a substantial effect on how the various issues in its Reports would be received and resolved. To anticipate such developments and to help monitor activities in the field, the Committee stated that "it would be in the best interests of the Victorian community if the Government established a standing review and advisory body which would continue and broaden the work it has already done". This body "should be empowered to examine and report on all matters in the field of the scientific and medical management of infertility, and related issues".[462] For example, the "question of embryo flushing or in vivo fertilization should be one matter considered by such a body, and should not be permitted unless the body so recommends".[463]

---

[458] *Ibid.*, para. 4.6, at 50.

[459] *Ibid.*, para. 4.11, at 52-53.

[460] *Ibid.*, para. 4.10, at 52. However, one would have thought that the ethical problems about disclosure of the child's origins — the fact of surrogacy itself, with the gestating mother different than the genetically related mother — would remain a very significant issue.

[461] *Ibid.*, para. 4.17, at 54.

[462] *Ibid.*, para. 5.4, at 56.

[463] *Ibid.* The body should also consider embryo cleavage, embryo surgery, and genetic manipulation: *ibid.*

(ii) Queensland, Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters

In 1984, a Special Committee on artificial conception, under the chairmanship of Mr. Justice A.G. Demack, published its *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters.*[464] Aside from artificial insemination and I.V.F., the Queensland Report dealt with surrogate motherhood, counselling and other related services, and the moral, ethical, social, economic, political, legal, and public policy issues raised by the new reproductive technologies.[465]

After describing the causes and treatment of infertility, chapter 3 delineated such basic principles guiding human conduct as the inherent dignity of the person, protection of the family as the natural and fundamental group unit of society, and the imperative to seek knowledge.[466] The Report noted that the advance of medical knowledge was not, in fact, an absolute goal, but must conform to notions of the public good.

With respect to the method or methods by which social control is exercised over medical science, the Report listed the establishment of ethical guidelines, the enactment of legislation, and the refusal of funding or facilities for certain projects.[467] Insofar as the promulgation of ethical norms was concerned, the Committee stated that no consensus existed with respect to several fundamental issues involved in artificial reproduction.[468] Moreover, rapid technological change appeared to be a constant feature.[469] Accordingly, the control of medical science through ethical rules was extremely difficult; such rules would have to be monitored and frequently revised.[470]

While the Committee's general position was that "medical practice should, so far as is possible, consistent with the public interest, be controlled through guidelines issued by responsible professional institutions", it was recognized that such regulation was not always possible or sufficient.[471] In some cases, legislation, including sanctions for breach of certain provisions, was required.[472] Significantly, the Committee adopted a type of compromise in respect of the selection of prospective participants in, for example, an I.V.F. programme. While it agreed that such selection should be left to the medical profession, at the same time it countenanced governmental intervention in order to assist "certain categories of persons rather than others", and considered it "proper for ethics committees to control the right of selection of patients to be admitted to an IVF and ET programme".[473]

---

[464] Queensland, *Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters* (1984) (hereinafter referred to as "Queensland Report").

[465] Issues of this nature were raised in the Committee's Interim Report of May 31, 1983, and restated in the Queensland Report: *ibid.*, at 10-14.

[466] *Ibid.*, at 40-41.

[467] *Ibid.*, at 44-45.

[468] *Ibid.*, at 45.

[469] *Ibid.*, at 51 *et seq.*

[470] For example, by an "institutional ethics committee" appointed for each institution in which research is undertaken, and by a proposed new, multidisciplinary Queensland Bioethics Advisory Committee, a general supervisory body established to advise the government and medical bodies: *ibid.*, at 46 *et seq.*

Among the values to be protected when considering the control of medical science, the Committee included the rights of the child, the rights of the family, the value of human life, and human dignity and integrity.[474] With respect to the rights of the child, the Committee was of the view that artificially conceived children "must be protected by legislation".[475] Such children were said to need:[476]

> (a) A name and identity ...;
>
> (b) Access to a reliable medical (genetic) history ...;
>
> (c) A man and a woman who are committed to their nurture, education and support ...;
>
> (d) The right to sue for any deleterious consequences of the artificial means used in conception ....

The preceding requirements led to the following "inferences":[477]

> - That the Registration of Births, Deaths, and Marriages Act should be amended to allow the man who is accepting paternal obligation to describe himself as father on the Birth Notification.
> - That provision be made for the keeping of sufficient medical and social information about the donor of sperm used to allow the child to have access to a reliable medical and social history.
> - That very strict screening procedures be adopted in the selection of donors.
> - That legislation ensure that the 'parents' (the people using the programme) shall have all the rights, duties and privileges of parents towards the child, and that the child shall have all the rights of a child to inherit from the 'parents'.

With respect to the rights of the family, the Committee dealt with two major questions: (1) whether artificial conception services should be open only to legally married couples; and (2) whether procedures should be permitted that may create children whose biological and social parentage differ.

---

[471] *Ibid.*, at 49.

[472] For example, in respect of the licensing of artificial conception centres: *ibid.*, at 50.

[473] *Ibid.*

[474] *Ibid.*, at 55 *et seq.*

[475] *Ibid.*, at 55.

[476] *Ibid.*, at 55-56.

[477] *Ibid.*, at 56.

The Report stated that, "[t]hough ... stability may not always be found in couples who are within a legal matrimonial relationship, it is assumed that the marriage commitment itself is evidence of stability".[478] However, to the extent that a *de facto* relationship had continued for a sufficient period to indicate a stable environment for the future child, artificial conception services for the couple involved was thought to be "appropriate".[479] No mention was made of single women as recipients.[480]

When the Committee returned to this topic, it stated that it would restrict admission, first, to those who have been unsuccessful in achieving pregnancy for at least two years or who have some genetic disease or "an obvious and otherwise irremediable bar to fertility".[481] Secondly, childless couples would be preferred.

A third factor related to the relationship of the couple in question:[482]

> [W]hile the Committee considers that there should be no legislative restriction on the extension of the process to de facto couples living in a stable relationship, it is of the opinion that at least priority should be given to married couples, and institutions licensed to provide an IVF service should be free to restrict it to married couples. The formal commitment to a stable relationship which is inherent in marriage, and the wider community acceptance of IVF within the framework of a married relationship, are seen as grounds for giving preference to a married couple. The embryo is produced in vitro in the confident expectation that there is a woman who is anxious to receive it and a family unit able to nurture the child into which the embryo may grow.
>
> It would be the responsibility of the medical team at an institution licensed to conduct an IVF programme[483] to decide whether or not to admit a particular couple to the programme.

A proposal extending medical services to unmarried, stable couples was also made in the context of A.I.D.[484]

---

[478] *Ibid.*, at 58-59.

[479] *Ibid.*, at 58.

[480] When noting that one other right pertinent to the discussion was the "right of access to public services", the Report stated that "access to infertility services should be made generally available" (*ibid.*, at 63). However, it does not appear that this statement was directed to the question whether, for example, single women or lesbian couples might be selected as recipients.

[481] *Ibid.*, at 81. See, also, *ibid.*, at 85, para. (vii).

[482] *Ibid.*, at 82. In the context of A.I.D., the Committee also stated that "submission to counselling should be a precondition to involvement ..." (*ibid.*, at 110).

[483] With respect to such institutions, see *ibid.*, at 82-83.

[484] *Ibid.*, at 99 *et seq.* The Committee's conclusions and proposals were as follows (*ibid.*, at 109):

The next chapter, chapter 4, dealt with I.V.F. and embryo transfer. The Report first canvassed the ethical considerations, raising such issues as the separation of procreation and marital love, the destruction of embryonic life, the danger of harm to the child, the freezing of embryos, and the use of donor gametes.[485]

With respect to the use or disposition of "surplus" embryos, the Committee would not countenance unrestricted experimentation.[486] However, it considered the question of the limits on experimentation to be largely beyond its terms of reference, although it would permit I.V.F. services that did not involve the deliberate loss or destruction of embryonic life. The Committee concluded that I.V.F. ought not to be precluded simply because of these ethical concerns. However, it did recommend that any extension of the present programme in Queensland — which, it said, does not involve any destruction of embryos — and any programme involving fetal research should first be approved by the proposed Queensland Bioethics Advisory Committee.[487]

The next concern raised was that of possible danger to the artificially conceived child. The Committee rejected the proposition that the critical fact was the inability of the embryo to consent, given the informed consent of the couple "for the benefit and well being of the future child".[488] Rather, the "real issue is whether IVF constitutes unacceptable experimental medicine".[489] In this connection, the Committee stated that I.V.F. children did not, in fact, exhibit any

---

> The Committee considers that the critical matter in this respect must be the position of the child conceived by AID. The interest of the child is best served by birth and development within a stable situation where both parents are responsible for its nurture. A situation where a child may be born to a woman who may not know who is the donor, where the anonymous donor will have no responsibility in caring for his offspring, and where the child will have no possibility of nurture by both his biological parents, is one which it considers should not be permitted to be fostered. We therefore consider that AID should normally only be administered in cases where the mother is married or is living in a stable de facto relationship with a man who consents to the AID.
>
> AID should be available only to couples who have an established infertility problem.

See, also, *ibid.*, at 112-13, respecting the availability of A.I.D. services in Queensland. The Committee proposed that A.I.D. should be made available "to public patients in public hospitals ... as part of an infertility service" (*ibid.*, at 112).

[485] *Ibid.*, at 65 *et seq.*

[486] Although the Committee noted that, of embryos conceived naturally, only approximately 20% survive: *ibid.*, at 67.

[487] *Ibid.*, at 72. With respect to research and experimentation, the Committee later stated that "a process which may help in alleviating the problem of infertility should not be banned simply because it may lead to undesirable forms of genetic engineering" (*ibid.*, at 80).

[488] *Ibid.*, at 73.

[489] *Ibid.*

abnormal levels of the usual disorders, although final conclusions with respect to all potential risks were not yet possible. In any event, the Committee concluded that "the prospect of possible hazard is not such as to require public intervention to ban the process or impose a moratorium on it".[490]

With respect to cryopreservation of embryos not immediately implanted, the process was justified so long as the risk of injury to the embryo was minimal,[491] the donors of the gametes consented,[492] and there was no risk where a subsequent transfer was attempted.[493] The Committee added that, if, later, it appeared that the risk was unacceptable, "IVF programmes should restrict the number of eggs fertilised to those necessary to accomplish a pregnancy".[494]

With respect to the use of donor gametes, the Committee stated that the "basic issue involved is the impact this may have on a family, including both the spouses and their children".[495] Of particular concern was the "possibility of psychological harm to the children who learn that they have been conceived in this way ...".[496]

The Committee perceived the question whether the use of donor gametes ought to be permitted or prohibited as involving a balance between the "public interest" and "private morality". It did not consider that the former required the banning of the use of donor sperm, but was not unanimous with respect to donor ova. However, the Committee agreed that certain restrictions should be imposed on ova donation:[497]

(a) the transfer should be part of treatment within an accepted family relationship;

(b) the recipient couple should intend to accept the duties and obligations of parenthood;

(c) consent should be obtained from the donor and the recipient couple;

(d) there should be no element of commerce between the donor and recipient couple.

It was recommended that the question whether to use donor gametes should be left to institutional ethics committees,[498] subject to certain limitations, including those outlined above. At a later juncture, the Report listed several more restrictions on the use of donor gametes.[499] For example, the Committee was opposed to the use of gametes from children and to the payment of donors.[500] It also was of the view that "[s]election of donors should be based not only on medical, but also on social and psychological consideration[s]".[501] Donors should be entitled to withdraw their previously given written consent[502] at any time before their gametes have been used.[503]

---

[490] *Ibid.*, at 74.

[491] *Ibid.*, at 75.

[492] *Ibid.*, at 76.

[493] *Ibid.*, at 77. The Committee suggested that cryopreservation should be restricted to 2 years, "except in exceptional circumstances": *ibid.*

[494] *Ibid.*, at 76.

[495] *Ibid.*, at 78.

[496] *Ibid.*

[497] *Ibid.*, at 79.

[498] *Ibid.* See, also, *ibid.*, at 84-85, paras. (i) and (ii). The Committee also dealt, in passing, with embryo donation. It recommended that safeguards and procedures similar to those

With respect to medical records, the Committee proposed that each hospital should keep its own register of donors, and non-identifying information should be made available to recipients.[504] In addition, there should be kept a confidential control register containing medical and social information about donors whose gametes have been successfully used.[505]

The Committee then turned to consider the regulation of I.V.F. It began by stating that "it would seem to be ultimately in the public interest that a programme be established publicly, under public authorisation, and under the supervision of persons of guaranteed competence".[506]

The Report discussed the regulation of I.V.F. under several topics. For example, the Committee dealt with admission to an I.V.F. programme, discussed earlier in this section. The Committee also considered such legal issues as (1) the status of the resulting children, (2) liability to the child, and (3) the disposition of genetic materials and embryos.

With regard to the status of the child, the Committee stated that I.V.F. created no special legal problems: the child's status would depend on who

---

applied in the case of adoption should be applied in the case of an embryo donation. There was no elaboration on this matter: see *ibid.*, at 79. At a later juncture, the Committee stated that donor embryos should be used only where the couple's infertility could not be overcome by other means or where the couple might transmit undesirable hereditary disorders: see *ibid.*, at 87, para. (xxv). See, also, *ibid.*, at 88. No embryo should be used without express written donor consent and no embryo should be created for experimental purposes: see *ibid.*, at 88, paras. (xxvii) and (xxviii), respectively

[499] *Ibid.*, at 84 *et seq.*

[500] *Ibid.*, at 86, paras. (xi) and (x), respectively.

[501] *Ibid.*, at 86, para. (xii).

[502] *Ibid.*, at 86, para. (xiv).

[503] *Ibid.*, at 86, para. (xv).

[504] *Ibid.*, at 87, paras. (xx) and (xviii), respectively. See, also, para. (xxii). No mention was made of access by children.

[505] *Ibid.*, at 87, paras. (xix) and (xxi).

[506] *Ibid.*, at 81.

supplied the sperm and ovum.[507] In this connection, the Committee recommended that "the provisions suggested in the case where a child is born as a result of donor sperm should be extended to the case of donor ova".[508]

With regard to liability to the child, the Committee concluded that the ordinary law respecting the liability of professionals would apply in the case of I.V.F., so that no special legislation was required.

Finally, with regard to the disposition of genetic materials and embryos, the Committee stated that gamete donors should be viewed as guardians of the gametes and, therefore, "able to make decisions about [their] use and even disposal" prior to the collection of the gametes.[509] Where the gamete donors disagreed, the issue should be determined by means of the procedure applicable in custody proceedings.[510] However, where this was not possible — for example, where the biological parents of a frozen embryo had died, giving no directions concerning disposition[511] — the procedure to be used should be that applicable in the case of adoption. Some, but not all, Committee members would have prohibited any disposition that would involve the deliberate destruction or injury to an embryo.[512]

Chapter 5 of the Queensland Report dealt with artificial insemination. The discussion was confined to A.I.D., since it was believed that A.I.H. did not appear to give rise to moral or social issues necessitating regulation in the public interest. Moreover, children born of A.I.H. would have the status of children of the marriage.[513]

As in the case of I.V.F., the Report canvassed the moral, ethical, social, and legal issues involved and, after deciding that some control of A.I.D. was necessary, discussed the form that such regulation should take. The moral issue focused in large measure on the objection that A.I.D. involved the illegitimate creation of a child outside marriage and, therefore, destroyed the integrity of the family. Another objection concerned the psychological impact of A.I.D. on the child.

The Report acknowledged that the community was deeply divided on the morality of A.I.D. Indeed, the Committee, after reciting the usual objections, did no more than describe the equally frequent responses — relating, for example, to the love expressed for each other and the future child in the couple's desire to have a child. It then turned its attention to the legal issues.

---

[507] *Ibid.*, at 88.

[508] *Ibid.*, at 88-89. Status in the case of A.I.D. was considered *ibid.*, ch. 5, to be discussed below.

[509] *Ibid.*, at 91.

[510] *Ibid.*, at 91-92.

[511] On June 19, 1984, both the Toronto *Globe and Mail* (at 11) and *The Toronto Star* (at A3) reported the death of the parents of 2 human embryos frozen in Australia, leaving an estate worth approximately $1 million.

[512] Queensland Report, *supra*, note 464, at 92.

[513] *Ibid.*, at 93.

The Committee began by stating that the A.I.D. "child should be treated in law as the legitimate child of the parties to that marriage, and should not be treated as the child of any person other than the parties to that marriage".[514] With respect to the husband's or partner's consent, the Committee concluded that, for the sake of certainty, the consent should be formally given and evidenced in writing, preferably before treatment, rather than rebuttably presumed.[515] Where consent is given, the "Registrar-General should register that man as the father of the child upon the production to him of the consent form or a certified copy thereof".[516]

The final legal issue canvassed concerned the disposition of sperm stored at a sperm bank or clinic. The Committee's proposal was as follows:[517]

> It is suggested that an appropriate rule would be that sperm provided for AID purposes will be at the disposition of the person or institution which operates the sperm bank or clinic, but that it will be required to carry out any undertakings it may have given the sperm donor as to its use and disposition. In other cases, the right of disposition of the sperm including post-mortem disposition will remain with the person who has supplied the sperm.

Subsequently, the Committee also recommended the enactment of legislation dealing with the operation of sperm banks and clinics.[518] Such institutions should be licensed and should be administered under proper medical supervision. Ethical guidelines should limit the number of inseminations from a particular donor, with semen from different donors to be kept separate. Donors should not be paid, although "travel expenses and loss of wages may be refunded ...".[519] Commercial exploitation respecting the procurement, collection, and disposition of semen should be prohibited. The use of A.I.D. for eugenic, selective purposes should also be prohibited, although the Committee appeared implicitly to adopt the view that the couple could, for example, choose the race or physical characteristics of the child; nor would the above proposal preclude the attempt to avoid harmful genetic traits. Finally, the Committee recommended the adoption of detailed guidelines, to be established by ethics committees and other qualified bodies and persons, dealing with the selection and screening of donors, the documentation of infertility investigations, the duration of sperm freezing, and sperm storage.[520]

---

[514] *Ibid.*, at 97.

[515] *Ibid.*, at 99.

[516] *Ibid.*, at 104.

[517] *Ibid.*

[518] *Ibid.*, at 110-11.

[519] *Ibid.*, at 110.

[520] *Ibid.*, at 111.

The Committee then turned to consider the regulation of A.I.D. While the Committee rejected the statutory rule, common in the United States,[521] that would legitimize the child only where the procedure was performed by a licensed physician,[522] it did acknowledge the "need for medical supervision and control over the technique" in order to protect both the recipient and her child.[523] But it also noted that, given the relatively simple nature of the procedure, it would be difficult to enforce any general prohibition against performance by laypersons not under the supervision and control of a doctor.

In this context, the Committee stated in chapter 5 that "control must be exercised over the persons who are permitted to administer" A.I.D.[524] However, in the summary of recommendations in chapter 8 it was recommended expressly that "[it] should be made an offence for any person to administer AID unless he is a registered medical practitioner or acts subject to the direction and [illegible] the supervision or control of a registered medical practitioner".[525]

In addition, the Committee favoured ethical guidelines, rather than legislation, to regulate matters other than those relating to the persons who should be permitted to administer the procedure.[526] A doctor who administers A.I.D. would be required to keep a history of the donor, a copy of which would have to be sent to the Department of Health. The identity of the donor would be confidential, except where a court ordered otherwise. Doctors would have access to the record, since, for example, information respecting the donor might be necessary to treat the child.[527]

Chapter 6 of the Queensland Report dealt with surrogate motherhood. The Report first reviewed the usual objections to surrogate motherhood: the depersonalization of reproduction; possible exploitation of paid surrogates; potential emotional harm to the child, any children of the surrogate, and the surrogate mother herself; and problems where there is a refusal to accept or keep a defective child, or where the prospective social parents die or divorce prior to the birth of the child. In addition, the Report stated that there was widespread opposition in the community and by professional bodies to any sanctioning of surrogate motherhood arrangements on moral and ethical grounds, with the spectre of "baby buying" used in many submissions to the Committee.

The Committee did not, however, believe it was necessary to criminalize surrogate motherhood arrangements, at least at present. But it was of the view that the problems were "such that the most prudent course would seem to be to leave such agreements unenforceable, at least until experience demonstrates whether regulation of such agreement[s] is required in the interest of society and of the parties involved".[528] Moreover, it was proposed that "it should be made illegal to advertise to recruit women to undergo surrogate pregnancy, or to provide facilities for persons who wish to make use of the services of such women".[529]

---

[521] See *infra*, this ch., sec. 3(c)(i)b(5).

[522] Queensland Report, *supra*, note 464, at 105.

[523] *Ibid.*

[524] *Ibid.*, at 108.

[525] *Ibid.*, at 143. See, also, *ibid.*, at 106-07. In order to ensure that a conscientious objection to participating in an A.I.D. procedure is respected, the Report recommended the legislative adoption of a "conscience clause" applicable to both physicians and institutions (*ibid.*, at 111-12).

[526] *Ibid.*, at 108.

[527] *Ibid.*

With respect to the medical, ethical, and social issues faced by doctors, the Committee recommended that guidelines should be adopted for the medical profession. With respect to the legal issues, the Committee believed that its proposal to keep surrogate motherhood arrangements void and unenforceable rendered it unnecessary to canvass such matters. Accordingly, questions of parental rights and obligations and custody would be settled by the application of the general law. However, the Committee did recommend "that any doubt which may exist that the woman who gives birth to a child is considered to be its mother, should be removed by legislation which so provides as an irrebuttable presumption".[530]

The final substantive chapter, chapter 7, dealt with counselling and related "support, communication and education" services, viewed by the Committee as "a crucial part of any infertility service".[531] For example, after identifying the potentially competing interests of all persons involved in artificial conception, the Report stated that an independent, comprehensive counselling service, focusing on social, psychological, and spiritual matters as well as physical and medical ones, would facilitate resolution of these interests in a manner that protects the child and permits decisions to be made by persons directly affected by infertility.[532] Counselling would normally be conducted by specially trained social workers, as well as other professionals, and not left solely to scientists and doctors.[533]

(iii) South Australia, Working Party on In Vitro Fertilization and Artificial Insemination by Donor

In 1983, the South Australian Minister of Health established a Working Party to study the legal issues relating to I.V.F. and A.I.D. The Working Party submitted its Report to the Health Commission in 1984.[534]

---

[528] *Ibid.*, at 116.

[529] *Ibid.*, at 118.

[530] *Ibid.*

[531] *Ibid.*, at 119.

[532] *Ibid.*, at 122.

[533] *Ibid.*, at 129.

[534] South Australia, *Report of the Working Party on In Vitro Fertilization and Artificial Insemination by Donor* (1984) (hereinafter referred to as "South Australia Report").

The Report began by emphasizing the view of the Working Party that, hitherto, insufficient attention had been paid to the interests of artificially conceived children. It was said that such interests should be given primary consideration.[535]

The first major portion of the Report was concerned with the legal status of artificially conceived children. The Working Party strongly endorsed proposed South Australian legislation[536] that would deem I.V.F. and A.I.D. children to be children of a marriage or a stable *bona fide* domestic relationship, and would give donors no legal status *vis-à-vis* the children.[537] The Working Party was of the view that adoption, which was necessary to legitimize a child born using donor gametes, was "neither practical for the couple nor sensitive to the needs of the child".[538]

In the next section, the Working Party addressed the standards of practice for A.I.D. and I.V.F. For example, the Report noted that, where donated gametes were involved, the "total anonymity of donors is maintained".[539] However, doctors responsible for the treatment did have access to donor records, to be used where it was medically necessary to identify individual donors.[540] The Working Party was of the view that the present practice justifiably protected the donor, the couple involved, and the artificially conceived child. The possibility that the couple might wish to maintain secrecy in respect of the child's origins was recognized without critical comment. Indeed, the Working Party "[considered] that it would be inadvisable to change present practices in this respect because of the potential effects on the family unit and the possible adverse effects on the future availability of male donors".[541] The Working Party, expressly disagreeing with the views given in the Victoria *Report on Donor Gametes in IVF* concerning the flow of information between the donor and the child,[542] stated that "total anonymity must be preserved to ensure that the best interests of the child and the donor are upheld".[543] Furthermore, the Working Party, rejecting the proposal of the Victoria *Report on Donor Gametes in IVF*,[544] recommended that "relatives, friends or known donors should not be selected to participate in an A.I.D. or I.V.F. procedure", having regard to "the likely sociological consequences for the child within the family unit";[545] in other words, only anonymous donors should be used.

---

[535] *Ibid.*, at 2.

[536] *Family Relationships Act Amendment Act, 1984*, Bill No. 4, 1984, s. 6, adding, *inter alia*, Part IIA to the *Family Relationships Act, 1975*.

[537] South Australia Report, *supra*, note 534, at 4.

[538] *Ibid.*, at 5.

[539] *Ibid.*, at 12.

[540] *Ibid.*

[541] *Ibid.* See, also, *ibid.*, at 19.

[542] Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.29 *et seq.*, at 26 *et seq.*

[543] South Australia Report, *supra*, note 534, at 24.

[544] Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.19-3.22, at 21-23.

With respect to I.V.F., the Working Party recommended that this procedure, which "should now be regarded as another routine procedure",[546] "should only take place in South Australia in recognized hospitals approved for that purpose by the South Australian Health Commission".[547] It was further proposed that the Health Commission should adopt the set of I.V.F. guidelines appended to the Working Party's Report.[548] Moreover, to ensure greater anonymity and better results where ovum donation was used, "funding should be made available to enable research to continue to find a safe method of freezing fertilized female gametes".[549]

In order to monitor I.V.F. programmes, and particularly the effects on children of using frozen embryos, the Report recommended that all I.V.F. pregnancies should be registered in a central repository, the National Perinatal Statistics Unit.[550] It was noted that, with respect to I.V.F., "the current incidence of congenital malformation based on international reports is less than occurs in the population as a whole".[551]

Insofar as eligibility for artificial conception treatment was concerned, the Report stated that availability for such services was limited by the number of professionals in the field, the size of the waiting lists, and budgetary constraints. The Report did not deal with the method by which persons should be selected for participation; it simply recommended that the Health Commission should review existing selection procedures in order "to rationalize priorities".[552]

After discussing the need for informed consent by a sperm or ovum donor,[553] the Report proposed that "[c]onsent once given should be able to be revoked prior to the donation".[554] It expressly rejected the approach of the Victoria *Report on Donor Gametes in IVF*, which would allow revocation even after donation.[555]

The Working Paper then turned to the use of gametes. With respect to research, it recommended that "fertilized gametes of human beings should never be used for scientific or genetic experimentation".[556] It had earlier proposed that fertilized gametes should not be maintained in a laboratory culture medium beyond the physiological stage at which implantation occurred.[557]

---

[545] South Australia Report, *supra*, note 534, at 28.

[546] *Ibid*., at 21.

[547] *Ibid*., at 14.

[548] *Ibid*., Appendix 6, at 50-51.

[549] *Ibid*., at 17.

[550] *Ibid*., at 14 and 18.

[551] *Ibid*., at 17.

[552] *Ibid*., at 21-22.

[553] *Ibid*., at 25.

[554] *Ibid*.

[555] Victoria Report on Donor Gametes, *supra*, note 356, paras. 3.17-3.18, at 21.

Where surplus frozen fertilized ova, not to be used by the couple, were involved, they should be disposed of on the written request of the couple; the couple "should not be entitled to donate those surplus fertilized gametes to any other person".[558] Moreover, where the marital or nonmarital relationship terminated, through death or divorce, for example, the fertilized ova should be disposed of.[559] The Working Paper went on to recommend that, "[i]n any event they should be disposed of at the expiration of an agreed period of time but in any event no longer than ten years from the date of commencing storage".[560]

The Report next considered the question of surrogate motherhood. Citing inevitable "social complications", where, for example, the surrogate mother refused to give up the child, the Working Party noted that the "community in general regards surrogacy as unacceptable".[561] Accordingly, it recommended that "there should be no change to the law to enable surrogacy to be practised in this State and that a policy should be formally adopted by the Government in relation to the *Adoption of Children Act* to prevent surrogacy being practised in South Australia".[562]

The last section of the Report dealt, *inter alia*, with the need to set priorities for participation in I.V.F. programmes, given the cost of medical care and the problems associated with multiple pregnancies (because of the transfer of multiple embryos to a woman). In respect of the latter, the Working Party advocated the freezing of embryos so that, if one transferred embryo did not result in a pregnancy, another could be transferred.[563]

---

[556] South Australia Report, *supra*, note 534, at 26.

[557] *Ibid.*, at 11.

[558] *Ibid.*, at 27. Again, the Working Party rejected the proposal in the Victoria Report on Donor Gametes, *supra*, note 356, para. 5.5, at 40, which would permit embryo donation. See, also, Victoria Report on Embryos, *supra*, note 421, paras. 2.8-2.10, at 27-28.

[559] South Australia Report, *supra*, note 534, at 27.

[560] *Ibid.*

[561] *Ibid.*, at 29.

[562] *Ibid.*

[563] *Ibid.*, at 32. The Report noted that a frozen embryo may also be wanted in order to have another child.

(d) UNITED STATES

(i) The American College of Obstetricians and Gynecologists

In 1983, the Executive Board of The American College of Obstetricians and Gynecologists approved a Statement of Policy respecting ethical issues in surrogate motherhood.[564] The College first delineated those ethical issues shared with "its logical counterpart", A.I.D. — for example, the tendency toward depersonalizing reproduction (particularly where the procedure is used to avoid interrupting careers), the potential creation of stress in a marriage, the risk of psychological stress in the sperm donor and surrogate mother, the possible adverse psychological effects on resulting children, the question of donor and surrogate mother anonymity, and the legal status of the children.[565]

However, the College also noted several issues that were unique to surrogate motherhood. For example, the surrogate mother must undertake both physical risks respecting the pregnancy and delivery, and psychological risks when the child is separated from her. Or, the surrogate mother may breach her agreement and decide to abort the fetus, or may keep the child after delivery. Or, for some reason, custody of the child may return to her by default.[566]

In addition to the issues raised above, financial arrangements were said to complicate the ethical picture. In particular, according to the College, the buying and selling of children is both illegal and immoral, and "[i]t is difficult to differentiate between payment for the service of carrying the child and payment for the child".[567] Moreover, payment to surrogate mothers beyond out-of-pocket expenses was said to raise the spectre of exploitation by potential social parents and by physicians who might recruit potential surrogates and parents.

Not surprisingly, the College stated that "[s]imple, clear conclusions cannot be anticipated" with respect to the issues raised by surrogate motherhood, even "in the most uncomplicated situation involving an infertile married couple and no financial transactions".[568] The College had "significant reservations"[569] about the procedure — although the decision to participate in it was left to the individual doctor — and offered several recommendations. Aside, for example, from those dealing with the need for counselling and the requirement that the surrogate be treated as any other obstetric patient,[570] the College considered the

---

[564] The American College of Obstetricians and Gynecologists, "Ethical Issues in Surrogate Motherhood", in ACOG Statement of Policy (May, 1983).

[565] *Ibid.*, at 1.

[566] *Ibid.*, para. 4, at 2.

[567] *Ibid.*, para. 1, at 2.

[568] *Ibid.*, at 2.

[569] *Ibid.*

[570] See *ibid.*, para. II.B, at 2:

> The surrogate mother should be considered the source of consent with respect to

screening of the surrogate mother and the couple. But it stated only that "[s]uch screening may include appropriate fertility studies and genetic screening".[571] There was no mention of screening in respect of nonmedical matters.

(ii) The American Fertility Society

In 1980, the Board of Directors of The American Fertility Society approved guidelines on artificial insemination, set forth in the *Report of the Ad Hoc Committee on Artificial Insemination.*[572] The Report dealt with the selection of donors, the selection and management of recipients, and cryopreservation. It also recommended model legislation and suggested forms to be used in the procedure.

Since the attempt of the Committee was "to provide minimal but feasible guidelines for practitioners",[573] much of the Report dealt with technical, medical matters that need not be discussed here. But the Committee also considered other issues. With respect to semen donors, reference was made, for example, to limiting the use of donors — a limit of fifteen successful pregnancies was suggested — and to avoiding the matching of donors and recipients from the "same area of family origin".[574] Perhaps to preclude payment being made for a body part, the Report recommended that the donation agreement should "indicate that any payment to the donor is to provide for transportation, inconvenience, and other incidental expenses incurred in donating the sample, rather than direct payment for the semen".[575]

Insofar as the selection of recipients was concerned, the Committee countenanced the use of A.I.D. (A.I.H. was not mentioned) in a specified number of cases, including where the husband was sterile, or had a genetic disorder or paraplegia, or had been exposed to environmental mutagens. Otherwise, it appears, A.I.D. would be proper only where there was "[a] history of infertility of at least one year duration, absence of contributing female factors (after proper evaluation), and abnormal sperm count and quality ...".[576]

Record keeping was also briefly addressed. In respect of the recipient, the "usual record" should be maintained, excluding the donor's name. In respect of the donor, a "coded record" should be kept.[577] The Report stated that the

---

clinical intervention and management of the pregnancy. Confidentiality between the physician and patient should be maintained. If other parties, such as the adoptive parents, are to play a role in decision making, the parameters should be clearly delineated, with the agreement of the patient.

[571] *Ibid.*, para. I.C.1, at 2.

[572] The American Fertility Society, *Report of the Ad Hoc Committee on Artificial Insemination* (1980).

[573] *Ibid.*, at 1.

[574] *Ibid.*, para. 9, at 5.

[575] *Ibid.*, para. 12, at 5.

[576] *Ibid.*, para. 1, at 8.

[577] *Ibid.*, para. 4, at 9.

attending physician or sperm bank "may consider biannual review and upgrading of donor records, and elimination of out-of-date records".[578] However, no indication was given concerning when records become obsolete.

A final section suggested that "other physicians involved in the care of the recipient" need not be, and "relatives, friends, ministers and the offspring" should not be, informed of the procedure.[579]

The model legislation in the Report dealt with A.I.D. alone. We need consider only a few of its provisions here.

The legislation provided that the procedure must be performed by a "licensed physician" or a "health practitioner under the direct supervision of a licensed practitioner".[580] However, even if this requirement is not met, "[n]o penalty shall accrue to any other party and the legal status of the parties, including any resulting child, shall not be affected".[581] In the model legislation, the artificially conceived child was deemed to be the legitimate child of the recipient and her consenting spouse, with all the rights of a child conceived naturally.[582] Moreover, the child would not be the donor's child "unless the donor is the husband of the mother".[583] The model legislation also provided that "[t]he donor shall have no rights in or liability to any child conceived through artificial insemination with donor semen, whether or not the donor's identity is known to the recipient".[584]

3. LEGISLATION

(a) INTRODUCTION

The growth in the practice of artificial conception has forced legislators to have regard to its implications and, in particular, to rethink traditional approaches to legitimacy and parenthood. Two Canadian jurisdictions, Quebec[585] and the Yukon Territory,[586] and at least twenty-five American states,[587] have responded by enacting artificial conception legislation. Several of the American statutes are based on the Uniform Parentage Act,[588] and a Uniform Child Status Act has been proposed in Canada and adopted in the Yukon Territory.[589] In addition, federal regulations in the United States deal, in part, with I.V.F. research or programmes conducted or funded by the Department of Health and Human Services.[590]

---

[578] *Ibid.*, para. 11, at 5.

[579] *Ibid.*, para. 5, at 9.

[580] Model legislation, "Qualified Practitioners", ss. 1 and 2.

[581] *Ibid.*

[582] *Ibid.*, "Resultant Child", s. 1.

[583] *Ibid.*, s. 2. It bears mentioning that the definition section states, in part, that "[n]o provisions of this act are intended to apply to artificial insemination with husband's semen". Of course, the donor could marry an unmarried recipient subsequent to the insemination.

[584] *Ibid.*, "Donor", s. 4. In addition, a provision (*ibid.*, "Practitioner", s. 2) exonerates the physician from liability where he "has complied with the provisions of this statute and has carried out a standard level of practice in the selection of donor or sperm bank, and in the processing and administration of the semen".

[585] *An Act to establish a new Civil Code and to reform family law*, S.Q. 1980, c. 39, s. 1, enacting, *inter alia*, arts. 586 and 588, dealing with artificial insemination.

---

[586] *Children's Act*, S.Y.T. 1984, c. 2, s. 14.

[587] See, for example: Ala. Code §§26-17-1 to 26-17-21; Alaska Stat. §25.20.045; Ark. Stat. Ann. §61-141 (1971); Cal. Civ. Code §7005 (West 1980); Colo. Rev. Stat. §19-6-106 (1978); Conn. Gen. Stat. Ann. §45-69-f-n (West Supp. 1980); Del. Code Ann., tit. 13, §§801-818; Fla. Stat. Ann. §742.11 (1981); Ga. Code Ann., tit. 74, §101.1 (1973); Hawaii Rev. Stat. §§584-1 to 584-26; Ill. Ann. Stat., ch. 40, §§2501-2526 (Smith-Hurd); Kan. Stat. Ann. §23-128-130 (1981); La. Civ. Code Ann. art. 188 (West Supp. 1980); Md. Est. & Trusts Code Ann. §1-206(b) (1974); Mich. Comp. Laws Ann. §700.111 (West Supp. 1980); Minn. Stat. Ann. §257.56 (West Supp. 1980); Mont. Rev. Codes Ann. §40-6-106 (1979); Nev. Rev. Stat. §126.061 (1979); N.C. Gen. Stat. §49A-1 (1976); N.J. Stat. Ann. §§9:17-38 to 9:17-59 (1983); N.Y. Dom. Rel. Law §73 (McKinney 1977); Ohio R.C. §§3111.01-3111.19; Or. Rev. Stat. §§109.239, 109.243, 109.247, 677.355, 677.360, 677.365, 677.370 (1979); R.I. Gen. Laws §§15-8-1 to 15-8-27; Tenn. Code Ann. §53-446 (Michie Supp. 1981); Tex. Fam. Code Ann., tit. 12, §12.03 (Vernon 1974); Va. Code §64.1-7.1 (Supp. 1979); Wash. Rev. Code §26.26.050 (1981); Wis. Stat. Ann. §891.40 (1980); and Wyo. Stat. §14-2-103 (1978).

[588] National Conference of Commissioners on Uniform State Laws, Uniform Parentage Act, Uniform Laws Annotated, Vol. 9A (hereinafter sometimes referred to as "UPA"). The states of Alabama, California, Colorado, Delaware, Hawaii, Illinois, Minnesota, Montana, Nevada, New Jersey, North Dakota, Ohio, Rhode Island, Washington, and Wyoming have enacted the UPA or a modification of it. See *supra*, note 587.

[589] For the Yukon Territory legislation, see *supra*, note 586. The Uniform Law Conference of Canada first adopted the Uniform Child Status Act at the Conference's 1980 meeting: Uniform Law Conference of Canada, *Proceedings of the Sixty-Second Annual Meeting* (1980), at 28-29. A revised version was subsequently adopted in 1982: Uniform Law Conference of Canada, *Proceedings of the Sixty-Fourth Annual Meeting* (1982), Appendix F (Uniform Child Status Act). See, also, *ibid.*, at 31. Section 11 of the statute deals with artificial insemination and I.V.F. where the semen is either that of a donor or of a husband or cohabiting partner, and provides solely for the legal status of the parties involved.

[590] 45 C.F.R. §46 (1982). Federal regulations promulgated by the United States Department of Health and Human Services seek to protect human subjects by requiring, for example, that H.H.S. grants or contracts respecting I.V.F. must be reviewed by an Institutional Review Board (§46.205). The Board reviews and monitors the selection of participants, consents, research activities, and other matters. The regulations do not appear to deal with embryos that are not to be implanted.

By way of background, it bears mentioning that, because of the controversy surrounding the ethics of I.V.F., in 1975 the United States Department of Health, Education, and Welfare (now the Department of Health and Human Services) imposed a moratorium on federal funding of I.V.F. research until the ethical issues were examined further. In 1978, after hearings, the Ethics Advisory Board of the Department announced that it would support the ethics of allowing federal funding so long as certain conditions were met. For example, where no embryo transfer was contemplated, no embryos should be sustained *in vitro* more than 14 days after fertilization. Where embryo transfer was to take place, such transfer should be attempted only with gametes obtained from lawfully

Considerable legislative activity has also taken place in Australia. For example, statutes in Victoria deal, *inter alia*, with the status of a child conceived by artificial insemination and I.V.F. where donor semen is involved, and with artificial conception facilities, counselling, eligibility of participants and donors, and medical records. Legislation in New South Wales provides essentially for the status of artificially conceived children.

While the statutes considered in the following sections of this Report do not deal exhaustively with the many issues raised by the new artificial conception technologies, they do deal with some critically important questions, particularly the status of an A.I.D. child. We now turn to consider these legislative developments.

(b) CANADA

(i) Quebec

Quebec was the first jurisdiction in Canada to pass legislation dealing with artificial insemination. Article 586 of the Civil Code[591] provides:

> 586. When a child has been conceived through artificial insemination, either by the father or, with the consent of the spouses, by a third person, no action for disavowal or contestation of paternity is admissible.

Reference should also be made to article 588:

> 588. Any interested person including the father or the mother may, at any time and by any means, contest the filiation of a person whose possession of status is not consistent with his act of birth.
>
> However, no person may contest the filiation of a person because that person was conceived through artificial insemination.

Thus, in Quebec, an A.I.D. child is, in effect, irrebuttably presumed to be the natural, legitimate child of the consenting spouse.[592]

---

married couples. See United States, Department of Health, Education, and Welfare, Ethics Advisory Board, *Report and Conclusions: HEW Support of Research Involving In Vitro Fertilization and Embryo Transfer* (1979), at 106-07, Conclusion (2), esp. (2)A.4 and (2)B.

[591] *Supra*, note 585. The wording of the Quebec legislation is similar to that of art. 188 of the Louisiana Civil Code (*supra*, note 587), which provides, in part, that "... [t]he husband ... cannot disavow paternity of a child born as the result of artificial insemination of the mother to which he consented". All of the other relevant statutes set out a positive presumption of legitimacy, as contrasted with a statutory inability to disavow or contest paternity.

[592] It is not provided that such consent must be in writing or witnessed. Moreover, it is unclear whether consent must be given prior to the insemination, although art. 586 may appear to imply that this is required.

(ii) Yukon Territory

In 1984, the Yukon Territory adopted,[593] almost verbatim, the part of the Uniform Child Status Act, proposed by the Uniform Law Conference of Canada, that dealt with human artificial conception.[594] Section 14 of the Yukon Territory *Children's Act* provides as follows:

> 14.-(1) In this section, 'artificial insemination' includes the fertilization by a man's semen of a woman's own ovum outside of her uterus and subsequent implantation of the fertilized ovum in her.
>
> (2) A man whose semen was used to artificially inseminate a woman is deemed in law to be the father of the resulting child if he was married to or cohabiting with the woman at the time she is inseminated even if his semen were mixed with the semen of another man.
>
> (3) A man who is married to a woman at the time she is artificially inseminated solely with the semen of another man shall be deemed in law to be the father of the resulting child if he consents in advance to the insemination.
>
> (4) A man who is not married to a woman with whom he is cohabiting at the time she is artificially inseminated solely with the semen of another man shall be deemed in law to be the father of the resulting child if he consents in advance to the insemination, unless it is proved that he refused to consent to assume the responsibilities of parenthood.
>
> (5) Notwithstanding a married or cohabiting man's failure to consent to the insemination or consent to assume the responsibilities of parenthood under subsection (3) or (4) he shall be deemed in law to be the father of the resulting child if he has demonstrated a settled intention to treat the child as his child unless it is proved that he did not know that the child resulted from artificial insemination.[595]
>
> (6) A man whose semen is used to artificially inseminate a woman to whom he is not married or with whom he is not cohabiting at the time of the insemination is not in law the father of the resulting child.

(c) UNITED STATES

(i) Artificial Insemination

a. General

In 1973, the National Conference of Commissioners on Uniform State Laws approved the Uniform Parentage Act.[596] This statute, enacted in whole or in part by fifteen states,[597] provides for the equal treatment and protection of children, regardless of the marital status of their parents.

---

[593] *Supra*, note 586.

[594] *Supra*, note 589.

[595] Where the closing flush of s. 14(5) applies, and given s. 14(6), it would appear that the child would have no legal father.

[596] *Supra*, note 588.

[597] See the states referred to in note 588, *supra*.

Section 5 of the Act, which deals with artificially conceived children, provides:

> 5.-(a) If, under the supervision of a licensed physician and with the consent of her husband, a wife is inseminated artificially with semen donated by a man not her husband, the husband is treated in law as if he were the natural father of a child thereby conceived. The husband's consent must be in writing and signed by him and his wife. The physician shall certify their signatures and the date of the insemination, and file the husband's consent with the [state department of health], where it shall be kept confidential and in a sealed file. However, the physician's failure to do so does not affect the father and child relationship. All papers and records pertaining to the insemination, whether part of the permanent record of a court or of a file held by the supervising physician or elsewhere, are subject to inspection only upon an order of the court for good cause shown.
>
> (b) The donor of semen provided to a licensed physician for use in artificial insemination of a married woman other than the donor's wife is treated in law as if he were not the natural father of a child thereby conceived.

It should be emphasized at the outset that the Uniform Parentage Act does not deal with access to artificial insemination services. Rather, section 5 deals with certain legal consequences of the procedure. The most significant feature of the section is that, where artificial insemination is carried out under the supervision of a licensed physician, there is established a legal parental relationship, with all its attendant rights and duties, between the recipient's consenting husband and the artificially conceived child, while expressly terminating those same rights and duties in the donor. Section 5 provides for confidentiality of records, while allowing access "for good cause shown" and by court order. Also of note is the fact that the provision applies to A.I.D. alone; insemination with the semen of the husband is apparently assumed not to raise a legitimacy question.[598]

The Commissioners' Comment to this section acknowledges that it is not comprehensive:[599]

> This Act does not deal with many complex and serious legal problems raised by the practice of artificial insemination. It was thought useful, however, to single out and cover in this Act at least one fact situation that occurs frequently. Further consideration of other legal aspects of artificial insemination has been urged on the National Conference of Commissioners on Uniform State Laws and is recommended to state legislators.

In addition to the states that have adopted the Uniform Parentage Act, several other states have enacted their own artificial insemination statutes. Although different in style, these statutes address several common issues.

---

[598] See Harris, "Artificial Insemination and Surrogate Motherhood — A Nursery Full of Unresolved Questions" (1981), 17 Willamette L. Rev. 913, at 917, and *In Re Adoption of Anonymous*, 74 Misc. 2d 99, 345 N.Y.S. 2d 430 (Surr. Ct. 1973).

[599] Uniform Laws Annotated, Vol. 9A, *supra*, note 588, at 593.

b. Issues Addressed by Artificial Insemination Legislation

(1) Married v. Single Women

The vast majority of the artificial insemination statutes are directed to married women, either expressly or implicitly. Section 5(a) of the Uniform Parentage Act provides that, where a "wife", with the consent of her "husband", is inseminated artificially with donated semen, "the husband is treated in law as if he were the natural father of a child thereby conceived". It should be emphasized, however, that this section does not preclude the artificial insemination of single women; as indicated earlier, the Act does not deal with access at all, but only with the legal consequences for an A.I.D. child born to a "married woman".[600]

Significantly, California, Colorado, Washington, and Wyoming modified section 5(b) by dropping "married" from "married woman". However, these states continue to use "wife" in subsection (a) and to use the restrictive phrase "with the consent of her husband". The implication is that the scheme reflected in modified section 5 is designed to legitimize an A.I.D. child born to a married couple, but also to ensure that the donor will have no responsibility even where the insemination of a single woman has occurred.

Outside the Uniform Parentage Act context, the Oregon legislation[601] arguably countenances, although implicitly, the insemination of single women.[602] While the language of most of the sections[603] refers to a married woman, section 677.365(1) provides that the request and consent of the woman is required prior to the insemination, as is the consent of her husband "if she is married".[604]

Whatever the implications for single women in respect of access to services, it is clear that the provisions relating to legitimacy under the artificial insemination statutes are limited to married couples. Primarily, the statutes deem the child to be legitimate where the recipient's husband has given his prior consent to the insemination. In this respect, the language of the legitimacy provisions is consistent, referring to "wife" and "married woman" throughout. Typical is the Florida legislation:[605]

> 742.11 Any child born within wedlock who has been conceived by the means of

---

[600] UPA, *supra*, note 588, §5(b).

[601] Or. Rev. Stat., *supra*, note 587.

[602] For the different viewpoints, see Harris, *supra*, note 598, at 934.

[603] Or. Rev. Stat. §§109.239 and 109.243.

[604] The Texas legislation, *supra*, note 587, raises the same issue by providing cryptically as follows (§12.03(b)): "If a woman is artificially inseminated, the resulting child is not the child of the donor unless he is the husband".

[605] Fla. Stat. Ann. §742.11 (1981).

artificial insemination is irrebuttably presumed to be legitimate, provided that both husband and wife have consented in writing to the artificial insemination.

(2) Consent

Like all medical procedures, artificial insemination by a physician requires the informed consent of the patient. Under the relevant American statutes, the consent of the mother is often assumed. The consent of her husband, however, usually has to be in writing, often witnessed by his wife, certified by the inseminating physician, and frequently kept in a sealed file. Section 5(a) of the Uniform Parentage Act and the legislation of the states that have adopted this provision take this approach.

While the American Uniformity Commissioners stressed the need to enact legislation that provided for the equal treatment of all children, section 5(a) of the Uniform Parentage Act does not appear to have fully achieved this goal. The Act requires the consent of the recipient's husband before he will be treated in law as the natural father of the child. Presumably, this provision reflects the view that the wish to bring a child into the family is, or ought to be, a joint one; accordingly, a non-consenting husband should not have the responsibilities of parenthood foisted upon him by the independent act of his wife.

Moreover, there is an intimate nexus between the manner of consent and the status of the child. Section 5(a) of the Uniform Parentage Act requires that the husband's consent "must be in writing and signed by him and his wife". It would therefore appear that, where these preconditions have not been satisfied, the husband would not be treated as the natural father of the child, notwithstanding his actual consent to the use of artificial insemination.[606] And, since the donor would bear no responsibility, having regard to section 5(b), the child would in fact have no legal father.

American statutes not based on the Uniform Parentage Act have taken various approaches to consent, although they generally stipulate that the husband's consent is necessary. Some states[607] require written consents from both husband and wife and make provision for filing such consents with the court or state registrar. Other states[608] require both consents, but do not specify particular filing requirements. On the other hand, several states[609] rebuttably presume the consent of the husband. And Tennessee, Louisiana, and Texas have adopted provisions similar to the Civil Code in Quebec.[610]

---

[606] The argument that the failure to follow these formalities would preclude the husband from being treated as the child's natural father is arguably buttressed, at least by implication, by a further provision in UPA, *supra*, note 588, §5(a). This section requires that the attending physician "shall certify their [the husband and wife's] signatures and the date of the insemination, and file the husband's consent with" the state department of health. However, "the physician's failure to do so does not affect the father and child relationship". No such saving provision appears in respect of the husband's formal consent requirement or the wife's signature on the consent form.

[607] See, for example: Conn. Gen. Stat. Ann. §45-69h; Kan. Stat. Ann. §23-130; Okla. Stat. Ann., tit. 10, §553; and Or. Rev. Stat. §677.365(2).

[608] See, for example: Fla. Stat. Ann. §742.11; Ga. Code Ann., tit. 74, §74-101.1(a); N.Y. Dom. Rel. Law §73(1) and (2); N.C. Gen. Stat. §49A-1 (1976); Va. Code §64.1-7.1 (Supp. 1979); and Alaska Stat. §25.20.045.

(3) The Donor

The American legislation generally reflects the traditional A.I.D. model where the donor is anonymous. For example, section 5(b) of the Uniform Parentage Act provides that the donor is treated as if he were not the child's natural father.[611] The remaining statutes terminate the donor's rights and responsibilities by implication, since they effectively deem the mother's husband to be the child's legal father.[612]

However, special mention should be made of legislation in Washington. The relevant provision significantly alters section 5(b) of the Uniform Parentage Act. It provides for an exception to the general rule — that a donor will not be treated in law as the natural father — where "the donor and the woman agree in writing that said donor shall be the father".[613] This modification may remove one obstacle to the recognition of a type of surrogate motherhood arrangement where the surrogate mother is not married or, if married, where her husband has not consented to the insemination (and, therefore, is not to be treated as the natural father).[614]

With respect to the selection of donors, only Oregon appears to have enacted express restrictions. The legislation provides that no semen may be donated by a person who has a transmissible disease or defect known to him or who knows or has reason to know he has a venereal disease.[615]

---

[609] See, for example: Ark. Stat. Ann. §61-141(c); Md. Est. & Trusts Code Ann. §1-206(b); and Mich. Comp. Laws Ann. §700.111(2).

[610] Tenn. Code Ann. §53.446; La. Civ. Code Ann. art. 188; and Tex. Fam. Code Ann., tit. 12, §12.03. For legislation in Quebec, see text following note 591, *supra*.

[611] See, also, Or. Rev. Stat. §109.239; Conn. Gen. Stat. Ann. §45-69j; and Tex. Fam. Code Ann., tit. 12, §12.03.

[612] The language used may differ. The child may be "legitimate" (Fla. Stat. Ann. §742.11), "natural and legitimate" (Alaska Stat. §25.20.045), or may have the same status as a "naturally conceived" child (Kan. Stat. Ann. §23.129, and Conn. Gen. Stat. Ann. §45.69i).

[613] Wash. Rev. Code Ann. §26.26.050(2).

[614] However, the consequences are not entirely clear in the admittedly rare case where the surrogate mother's husband does expressly consent to her insemination and, as well, the donor and the surrogate mother "agree in writing that said donor shall be the father". Does the child have two fathers, the surrogate mother's husband and the donor? The statute does not render §5(a) inapplicable where such an agreement takes place.

With respect to whether certain paternity and artificial insemination statutes apply where there is a surrogate motherhood arrangement, see *Syrkowski v. Appleyard*, 122 Mich. App. 506, 333 N.W. 2d 90 (1983).

[615] Or. Rev. Stat. §677.370 (1979).

(4) Medical Records

It is interesting to note that, under section 5(a) of the Uniform Parentage Act, the filed consents and the date of insemination are the only records of the insemination actually required. Although section 5(a) also provides that any other information that is held by the physician, the court, or other person or agency is subject to inspection "upon an order of the court for good cause shown", the section does not require anyone to keep information beyond the filed consents and the insemination date. The ability of a child or interested party to obtain such information as the child's genetic history would depend, therefore, on the record keeping of the particular inseminating physician (which, of course, might be governed by separate legislation or rules).

(5) The Performance of Artificial Insemination and Its Implications

Many of the statutes that legitimize A.I.D. children apply only where artificial insemination is performed by a licensed physician. As a result, where artificial insemination has been performed by a layperson, legitimization cannot be achieved. If, however, as in section 5(a) of the Uniform Parentage Act, the procedure may be performed "under the supervision of a licensed physician", A.I.D. children could be legitimized where the procedure was performed by the husband or a third person, so long as a physician had the requisite control.

Some states specifically provide for more than legitimization; they deal with the practice of artificial insemination itself. In some cases, only a licensed physician may perform A.I.D.[616] In other cases,[617] the performance of artificial insemination is prohibited unless it is undertaken by or under the supervision of a physician. Several states do not mention by whom the procedure must be carried out.

(ii) *In Vitro* Fertilization, Embryo Transfer, and Fetal Research

At present, over twenty American states have passed legislation governing fetal experimentation and research, several of which may potentially cover aspects of I.V.F. and embryo transfer.[618] However, it is important to bear in mind that the statutes are, in large part, the result of the abortion decision of the

---

[616] See, for example, Okla. Stat. Ann., tit. 10, §553.

[617] See, for example: Ga. Code Ann., tit. 74, §101.1(b); Conn. Gen. Stat. Ann. §45-69g; and Or. Rev. Stat. §677.360. The Oregon section provides that "[o]nly physicians licensed under this chapter and persons under their supervision may select artificial insemination donors and perform artificial insemination".

[618] See, for example: Me. Rev. Stat. Ann., tit. 22, §1593 (West 1980); Mass. Gen. Laws Ann., ch. 112, §12J (West Supp. 1983); Mich. Comp. Laws Ann. §§333.2685-333.2692 (West 1980); Mont. Rev. Codes Ann. §50-20-108(3) (1981); N.M. Stat. Ann. §24-9A (1981); N.D. Cent. Code §14-02.2 (Allen Smith 1981); R.I. Gen. Laws §11-54 (Supp. 1982); S.D. Comp. Laws Ann. §34-23A-17 (1977); and Utah Code Ann. §76-7-310 (Allen Smith 1978).

United States Supreme Court in *Roe v. Wade*.[619] In that case, the Court held that the state could not interfere with a woman's right to have an abortion within the first trimester of pregnancy. Consequently, it was contemplated that doctors and others would be faced with the question whether it was legally permissible to study or to experiment on an aborted fetus.

The statutes either prohibit or substantially restrict certain types of "experimentation"; many provisions also cover "research" or "study". With respect to these pursuits, we noted in chapter 3 the suggestion of one commentator in 1975 that, while I.V.F. was still experimental, it may be more apt to call the procedure therapeutic innovation rather than pure experimentation.[620] However, we also observed that the artificial reproduction technologies have gone through several significant stages of development since 1975. Accordingly, the historical context within which the various Acts were passed, and the language,[621] tenor, and purpose of those Acts, raise the argument that they were simply not directed toward the use of the artificial conception technologies directly on humans for the sole purpose of conceiving a child.

Only the New Mexico statute mentions I.V.F. expressly: it prohibits certain kinds of "clinical research activity" on fetuses. "Clinical research" is to be "construed liberally to embrace research concerning all physiological processes in man and includes research involving human in vitro fertilization".[622]

Yet, even here, it is arguable that the provision is not, in fact, designed to prohibit I.V.F. as such. The phrase "research involving human in vitro fertilization" seems a rather oblique means of precluding the direct application of I.V.F. to patients.

While the statutes may, therefore, be limited in scope, many of them may preclude research and experimentation on, for example, "surplus" fertilized ova not implanted in the recipient. Most of the Acts prohibit experimentation on "live" or "living" embryos, fetuses, or concepti. Some statutes define "live" or "living" in a narrow way, so that I.V.F. would not be affected.[623] But others ban experimentation in a more general manner,[624] often contrasting experimentation on "live" fetuses with experimentation on "dead" ones.[625] Where these terms are not defined, or not defined narrowly, research and experimentation on fertilized ova that are not implanted may well be affected by the statutes.

---

[619] 410 U.S. 113 (1973).

[620] Dickens, "What is a medical experiment?" (1975), 113 Can. Med. Ass'n J. 635. See *supra*, ch. 3, text accompanying note 17.

[621] Indeed, many of the statutes clearly would not affect I.V.F. Of the states in question, almost half cover research only where an abortion is anticipated or has been performed. Other states cover only research on a fetus that exhibits a heartbeat, spontaneous respiratory activity, spontaneous voluntary muscle movement, or pulsation of the umbilical cord. (In the latter case, however, one statute defines "living" as having "the presence of evidence of life, such as" some of the indicators just described. If this provision is to be read *ejusdem generis*, the statute would not apply to I.V.F. If, however, "evidence of life" is not so read, and if it includes, for example, an embryo, then the statute might well be relevant: see, for example, Minn. Stat. Ann. §145.421(3).)

[622] N.M. Stat. Ann. §24-9A-1(D).

[623] See *supra*, note 621.

With respect to the possible application of the statutes to *in vivo* fertilization and embryo transfer, it should be noted that several states prohibit experimentation on aborted fetuses. In some cases, the definition of abortion may appear to be broad enough to include the nonsurgical "flushing" technique used in extracting a fertilized ovum from the body.[626] However, it bears re-emphasizing that the legislation is directed to experimentation and research on the human material; it may, therefore, say nothing of embryo transfer *per se*.

Some of the statutes also prohibit persons from selling a fetus,[627] while others prohibit persons from giving away[628] or permitting someone else to use a fetus. But, once again, the prohibited conduct is only in relation to experimentation and research.

Unlike the abovementioned statutes governing research and experimentation, new legislation in Pennsylvania deals not only with I.V.F. as experimentation, but also with I.V.F. as a means of circumventing infertility. The legislation is, however, rather narrowly framed, in that it merely requires the filing of public reports on I.V.F. with the Department of Health.[629] Thus, it essentially serves to monitor, rather than actively regulate, the procedure.[630]

---

[624] See, for example, the statute in Rhode Island, *supra*, note 618.

[625] See, for example, the provisions in Massachusetts and North Dakota, *supra*, note 618.

[626] In Oklahoma, for example, an abortion includes the administration of any substance intended to cause expulsion of a conceptus, zygote, morula, blastocyst, or embryo: Okla. Stat. Ann., tit. 63, §1-730(1), (2), and (7) (West Supp. 1982-83).

[627] See, for example: Minn. Stat. Ann. §145.422(3) (West Supp. 1982), and Ohio Rev. Code Ann. §2919.14(A) (Baldwin 1982).

[628] See, for example: Ky. Rev. Stat. Ann. §436.026 (Baldwin 1975); Mass. Gen. Laws Ann., ch. 112, §12J(a)IV (West Supp. 1982); and Mich. Comp. Laws Ann., §333.2690 (West 1980).

In Illinois, legislation[631] provides that a physician who fertilizes a woman's egg *ex utero* becomes the custodian of the offspring for the purpose of an 1877 child abuse statute.[632] Given the context within which the latter Act was enacted, it is easy to see why a great many serious concerns have apparently been expressed by Illinois physicians, few of whom appear to use I.V.F.[633]

(d) AUSTRALIA

(i) Victoria

In 1984, the Victoria Legislature enacted two statutes dealing with artificial conception: the *Status of Children (Amendment) Act* 1984[634] and the *Infertility (Medical Procedures) Act* 1984.[635]

The first statute enacted a new Part II of the *Status of Children Act* 1974.[636] Part II deals with the status of children produced by artificial insemination where the semen used was not that of the woman's husband or was a mixture of her husband's semen and donor semen, and by I.V.F. where either the ovum or sperm is donated or where there is both donor sperm and donor ovum. Part II does not deal with A.I.H., but it does address the use of artificial insemination on an unmarried woman and a woman acting without the consent of her husband. For some reason, however, there are no comparable provisions respecting the use of I.V.F. on such women.

---

[629] Pa. Stat. Ann., tit. 18, §3213(e) (Purdon). The main part of the section provides for the filing of the following information:

> (1) Names of all persons conducting or assisting in the fertilization or experimentation process.
>
> (2) Locations where the fertilization or experimentation is conducted.
>
> (3) Name and address of any person, facility, agency or organization sponsoring the fertilization or experimentation except that names of any persons who are donors or recipients of sperm or eggs shall not be disclosed.
>
> (4) Number of eggs fertilized.
>
> (5) Number of fertilized eggs destroyed or discarded.
>
> (6) Number of women implanted with a fertilized egg.

It bears mentioning that the names of donors and recipients are not required under the legislation.

[630] Although, presumably, the former may be a prelude to the latter where state officials deem some form of intervention to be necessary or desirable.

[631] Ill. Ann. Stat., ch. 38, §81-26(6) (Smith-Hurd Supp. 1984-85).

[632] Ill. Ann. Stat., ch. 23, §2354 (Smith-Hurd).

[633] For example, is it a crime to dispose of a defective embryo? The Illinois law also makes it a criminal offence for the physician to allow another person to endanger a child created by I.V.F. Just how far this provision is entitled to go is not at all clear. Must the physician constantly monitor a pregnant woman?

[634] *Status of Children (Amendment) Act* 1984, No. 10069.

[635] *Infertility (Medical Procedures) Act* 1984, No. 10163.

[636] *Status of Children Act* 1974, No. 8602, as am. by No. 9863.

Essentially, Part II provides that where a married woman, with the consent of her husband, has undergone A.I.D. or I.V.F., the husband is irrebuttably presumed to be the father of the child and the ovum or semen donor is irrebuttably presumed not to be the mother or father.[637] In addition, where semen is used to inseminate artificially an unmarried woman or a woman who has not obtained the consent of her husband, "the man who produced the semen has no rights and incurs no liabilities" in respect of the resulting child unless, at any time, he becomes the woman's husband.[638]

A reference to a husband or wife includes a "person [who] is living with another person of the opposite sex as his or her spouse on a *bona fide* domestic basis although not married to the other person" and excludes, in the above case, "the spouse (if any) to whom the person is actually married".[639]

Under Part II, the husband's consent is presumed, but the presumption is rebuttable.[640] While Part II does not provide expressly for the consequences where the presumption of consent is rebutted, it would seem to follow that the non-consenting husband would not be the parent of the child. Since the donor is presumed irrebuttably not to be the father, the child would have no legal father in such a case.

Finally, the statute does not expressly state whether the consent must be written or when it must be given. Insofar as the form of consent is concerned, there seems to be no reason to assume from silence that it must be reduced to writing. With respect to the timing of consent, it is arguable that the language of the sections implies prior consent: they provide for the case where "a married woman, in accordance with the consent of her husband, *has undergone*"[641] the procedure in question.

Notwithstanding the title of the *Infertility (Medical Procedures) Act* 1984, the ambit of that statute extends beyond purely medical procedures to include such important matters as approval of facilities, counselling, eligibility criteria for recipients and donors, consents, payments to donors, donation by minors, hospital and other records, and disclosure of information. The Act covers I.V.F. with no donors, donor sperm, donor ova, and both donor sperm and donor ova. Artificial insemination is covered only by a few provisions. Finally, the Act deals with experimentation, embryo freezing, embryo donation, false or misleading statements by gamete donors, the establishment of a Standing Review and Advisory Committee and an Administrative Appeals Tribunal, and surrogate motherhood.

---

[637] *Status of Children (Amendment) Act* 1984, *supra*, note 634, s. 5, enacting new ss. 10C(2), 10D(2), and 10E(2).

[638] *Ibid.*, s. 5, enacting new s. 10F(1).

[639] *Ibid.*, s. 5, enacting new s. 10A(2).

[640] *Ibid.*, s. 5, enacting new ss. 10C(4), 10D(4), and 10E(4).

[641] *Ibid.*, s. 5, enacting new ss. 10C(2), 10D(2), and 10E(2) (emphasis added).

It would appear that the Act prohibits all means of artificial conception other than artificial insemination and I.V.F. where the latter is carried out in accordance with the Act. Accordingly, it would seem to preclude, for example, the use of *in vivo* fertilization and lavage.[642]

In addition to regulating artificial conception in the manner just described, the Act establishes certain mandatory rules, breach of which may involve the imposition of a sanction. For example, the procedures permitted by the Act must be performed at a hospital approved by the appropriate Minister.[643] Such approval may be given subject to terms and conditions,[644] which may be varied.[645] The approval may be cancelled where the hospital or one of its designated officers[646] commits an offence under the Act or where the hospital fails to comply with a term or condition to which it is subject.[647] Where a person commits an offence under the Act in an approved hospital, the hospital and its designated officer are also guilty of an offence.[648]

---

[642] See *Infertility (Medical Procedures) Act* 1984, *supra*, note 635, s. 5(1), which provides that, "[s]ubject to sub-section (2), a person shall not carry out a fertilization procedure". Section 5(2) provides that "[s]ub-section (1) does not apply to a person who carries out a relevant procedure in accordance with this Act". The term "fertilization procedure" is defined in s. 3(1) to mean a "relevant procedure" or

> (b) any other procedure (other than the procedure of artificial insemination) for implanting in the body of a woman —
>
> (i) an ovum produced by that woman or by another woman, whether or not it is fertilized outside the body of the first-mentioned woman; or
>
> (ii) an embryo derived from an ovum produced by that woman or by another woman whether or not it is fertilized outside the body of the first-mentioned woman.

A "relevant procedure" is defined in s. 3(1) to mean "a procedure to which section 10, 11, 12 or 13 applies". Section 10 deals with I.V.F. using no donors; s. 11 deals with I.V.F. using donor semen; s. 12 deals with I.V.F. using donor ovum; and s. 13 deals with I.V.F. using donor sperm and ovum.

It would seem that clause (b) of the definition contemplates, *inter alia*, *in vivo* fertilization of an ovum of "another woman" — since such a procedure would be fertilization "outside the body of the first-mentioned woman" — and its subsequent transfer to the latter woman. Given that s. 5 prohibits all "fertilization procedures" except "relevant procedures" performed in accordance with the Act, the use of *in vivo* fertilization and lavage, not being a "relevant procedure", would appear to be precluded.

[643] *Ibid.*, ss. 7, 10(2), 11(2), 12(2), and 13(2).

[644] *Ibid.*, s. 7(3).

[645] *Ibid.*, s. 7(4).

[646] *Ibid.*, ss. 3(1) and 8, respecting a "designated officer".

[647] *Ibid.*, s. 7(5) and (6).

While, as indicated, artificial insemination is not covered by most of the provisions of the Act, as a result of section 7(7) a hospital may apply for approval as a place at which artificial insemination may be conducted. However, section 17(2) expressly provides that the normal rule, expressed in section 17(1) — that a "person, who is not a medical practitioner shall not carry out a procedure of artificial insemination" — does not apply "to a person who carried out a procedure of artificial insemination in an approved hospital". Moreover, although section 21 deals with medical records, it does envisage that artificial insemination may be carried out by a doctor outside an approved hospital.

We turn now to the prerequisites to the carrying out of I.V.F. under the statute. With respect to eligibility, I.V.F. may not be performed on an unmarried woman.[649] A married woman includes a woman who is "living with a man as his wife on a *bona fide* domestic basis although not married to him".[650] In all cases, both spouses or partners must consent in writing.[651]

Before undergoing I.V.F., the couple must be examined and treated by a doctor other than the I.V.F. physician. The doctor must be satisfied that the woman would not become pregnant except by artificial means and, where donor gametes are used, that if she were to become pregnant as a result of the use of her own ovum or her spouse's or partner's sperm, or both, "an undesirable hereditary disorder may be transmitted" to the resulting child.[652] In addition, the I.V.F. physician must be satisfied that the couple has undergone counselling by an approved counsellor[653] and that post-I.V.F. counselling will be available.[654]

A physician may not use a donated gamete unless the donor and his or her spouse (if any) have consented in writing to its use, have not withdrawn that consent, and have received counselling from an approved counsellor.[655] Where a donor or his or her spouse withdraws consent by notice in writing, the gametes must be destroyed unless the donor or spouse has consented to the use of the gametes in another I.V.F. procedure or the gametes have already been used.[656] No payment, except for travelling and medical expenses, may be made to a donor.[657] Finally, it is an offence for a gamete donor to give a false or misleading statement, unless he or she believed on reasonable grounds that the statement was true or not misleading.[658]

---

[648] *Ibid.*, s. 28.

[649] *Ibid.*, ss. 10(3)(a), 11(3)(a), 12(3)(a), and 13(3)(a).

[650] *Ibid.*, s. 3(2)(a)(i).

[651] *Ibid.*, ss. 10(3)(b), 11(3)(b), 12(3)(b), and 13(3)(b). Where there is gamete donation, the consents must not have been withdrawn: *ibid.*, ss. 11(3)(b), 12(3)(b), and 13(3)(b). For some reason, there is no mention of the withdrawal of consents where there is no gamete donation: see *ibid.*, s. 10(3)(b). In addition, the consent documents are retained by the hospital, with copies going to the recipient and her spouse or partner: *ibid.*, ss. 11(4), 12(4), and 13(4).

[652] *Ibid.*, ss. 10(3)(d), 11(3)(d), 12(3)(d), and 13(3)(d).

[653] The approval of counsellors is dealt with *ibid.*, s. 9.

[654] *Ibid.*, ss. 10(3)(e), 11(3)(e), 12(3)(e), and 13(3)(f).

[655] *Ibid.*, ss. 11(5), 12(5), and 13(5) and (6).

With respect to the source of the gametes, the Act provides that, where both ova and sperm donors are involved, I.V.F. should not be carried out unless, "where more than one embryo is used in the procedure, the gametes from which each embryo was derived were produced by the same two persons ...".[659] In addition, neither artificial insemination nor I.V.F. may be performed where the semen used was produced by more than one man.[660]

The Act also provides that gametes from an identified donor may be used, but only so long as the designated officer of an approved hospital certifies in writing that the same criteria for assessing suitability has been applied to this donor as would be applied to other, anonymous donors, and that the recipient, her husband or partner, and donor have received additional counselling respecting the use of the gametes of an identified donor. In no case may an unmarried person under the age of eighteen years be used as a gamete donor.[661]

Where an embryo, intended for implantation in an I.V.F. procedure, cannot be implanted because, for example, the recipient has died, the embryo may be donated by the gamete donors to another woman. Where the donors' consent for donation cannot be obtained, the Minister of Health must direct that the embryo be made available for use in an I.V.F. procedure.[662]

In section 6 of the Act, provision is made for experimentation and embryo freezing. After prohibiting cloning and any "procedure under which the gametes of a man or a woman are fertilised by the gametes of an animal",[663] section 6(3) prohibits all kinds of "experimental procedure"[664] except those approved by the Standing Review and Advisory Committee, established under section 29. In addition, section 6(5) prohibits the *in vitro* fertilization of ova for any purpose except implantation of the embryo in an I.V.F. procedure.

---

[656] *Ibid.*, s. 15.

[657] *Ibid.*, ss. 11(6), 12(6), and 13(7).

[658] *Ibid.*, s. 27.

[659] *Ibid.*, s. 13(3)(e).

[660] *Ibid.*, s. 26.

[661] *Ibid.*, s. 25.

[662] *Ibid.*, s. 14(1).

[663] *Ibid.*, s. 6(1) and (2).

[664] The term "experimental procedure" is defined in s. 6(4) to mean "a procedure that involves carrying out research on an embryo of a kind that would cause damage to the embryo, would make the embryo unfit for implantation or would reduce the prospects of a pregnancy resulting from the implantation of the embryo".

Finally, section 6 provides that a "person shall not carry out a procedure that involves freezing an embryo",[665] unless the embryo is "to be implanted in the womb of a woman at a later date".[666] However, research relating to the freezing of ova is expressly permitted.[667]

The statute also deals with record keeping. An approved hospital must maintain a register containing particulars of gamete donors and of the use of their gametes, the resulting child, consents, payments to donors, and any destruction of gametes,[668] in respect of both I.V.F. and artificial insemination.[669]

Non-identifying information respecting particulars of the donor must be given to the recipient, and the hospital must offer the donor non-identifying information concerning the recipient. In addition, a donor may request from the hospital that he or she be given non-identifying information respecting the artificially conceived child.[670]

Section 21 provides for record keeping where the artificial insemination procedure carried out by a physician is not performed in an approved hospital. In these cases, the physician must keep a written record of the particulars of the semen donor and any resulting child and send a copy to the Health Commission.

Section 22(1) of the Act requires the Health Commission to keep a central register. This register is to contain copies of the records sent to the Commission under section 19 or 21. With respect to disclosure, and leaving aside information that may flow to the donor and the recipient,[671] the regulations may prescribe classes of persons who may have access to specified portions of the Health Commission's register, subject, if necessary, to terms and conditions. In addition, the regulations may provide that the Minister or Secretary of the Health Commission may permit specified persons or classes of persons to have access to the register.[672] Finally, section 23 generally prohibits disclosure by persons who have access to certain medical records.

In Part V of the Act, the practice of surrogate motherhood is dealt with. The legislation is broadly conceived, covering women who, either before or after they become pregnant, agree with another person to act as surrogate mothers, whether or not for payment or reward. Section 30(2) and (3) then provides as follows:

---

[665] *Ibid.*, s. 6(6).

[666] *Ibid.*, s. 6(7).

[667] *Ibid.*, s. 6(8).

[668] *Ibid.*, s. 19(2).

[669] *Ibid.*, s. 19(5).

[670] *Ibid.*, s. 20.

[671] *Ibid.*

[672] *Ibid.*, s. 22(2) and (3).

> 30.-(2) A person shall not—
>
> (a) publish, or cause to be published, a statement or an advertisement, notice or other document that—
>
> (i) is intended or likely to induce a person to agree to act as a surrogate mother;
>
> (ii) seeks or purports to seek a woman who is willing to agree to act as a surrogate mother; or
>
> (iii) states or implies that a woman is willing to agree to act as a surrogate mother;
>
> (b) make, give or receive, or agree to make, give or receive, a payment or reward for or in consideration of the making of a contract, agreement or arrangement under which a woman agrees to act as a surrogate mother; or
>
> (c) receive or agree to receive a payment or reward in consideration for acting, or agreeing to act, as a surrogate mother.
>
> . . .
>
> (3) A contract or agreement (whether made before or after the commencement of this section) under which a woman agrees with another person or other persons to act as a surrogate mother is void.

(ii) New South Wales

In 1984, New South Wales passed the *Artificial Conception Act, 1984*,[673] dealing essentially with the status and paternity of artificially conceived children. The main substance of the Act reads as follows:

> 5.-(1) A reference in this section to a fertilisation procedure is a reference to —
>
> (a) the artificial insemination of a woman; or
>
> (b) the procedure of implanting in the womb of a woman an ovum produced by the woman and fertilised outside her body,
>
> where the semen used for the artificial insemination or the procedure —
>
> (c) was produced by a man other than her husband; or
>
> (d) was a mixture of semen, part of which was produced by a man other than her husband and part of which was produced by her husband.
>
> (2) Where a married woman, in accordance with the consent of her husband, has undergone a fertilisation procedure as a result of which she has become pregnant, the husband shall be presumed, for all purposes, to have caused the pregnancy and to be the father of any child born as a result of the pregnancy.
>
> (3) The presumption of law that arises by virtue of subsection (2) is irrebuttable.
>
> (4) In any proceedings in which the operation of subsection (2) is relevant, a husband's consent to the carrying out of a fertilisation procedure in respect of his wife shall be presumed, but that presumption is rebuttable.
>
> 6.-(1) Where a woman becomes pregnant by means of —
>
> (a) artificial insemination; or

---

[673] *Artificial Conception Act, 1984*, Act No. 3, 1984.

> (b) the procedure of implanting in her womb an ovum (whether or not produced by her) fertilised outside her body,
>
> any man (not being, in the case of a married woman, her husband) who produced semen used for the artificial insemination or the procedure shall, for all purposes, be presumed not to have caused the pregnancy and not to be the father of any child born as a result of the pregnancy.
>
> (2) The presumption of law that arises by virtue of subsection (1) is irrebuttable.

The Act provides that a "married woman" includes "a woman who is living with a man as his wife on a bona fide domestic basis although not married to him".[674]

Insofar as the status of the child is concerned, section 5(1)(b) does not contemplate the use of donor ova. Accordingly, it would appear that, where, with her husband's consent, a "married woman" has had implanted in her an ovum produced by another woman and fertilized by donor semen, the husband would not be presumed to be the father of the child. As a result, where a donor ovum is used, the child would appear not to have a legal father, since, under section 6(1)(b) of the Act, the semen donor would have no status.

Reference should also be made to the companion statute, the *Children (Equality of Status) Amendment Act, 1984*,[675] which deals with conflicts between presumptions under the *Artificial Conception Act, 1984*, and the *Children (Equality of Status) Act, 1976*,[676] relating to the establishment of paternity and maternity.

---

[674] *Ibid.*, s. 3(1). The terms "husband" and "wife" have correspondingly expanded definitions: *ibid.*, s. 3(2).

[675] *Children (equality of Status) Amendment Act, 1984*, Act No. 6, 1984.

[676] *Children (Equality of Status) Act, 1976*, Act No. 97, 1976.